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ABSTRACT

This report describes the results of a regional needs assessment of workforce issues related to the delivery of community-based services for children and adolescents with serious emotional disturbance or mental illness and their families in a region comprising 12 southern states. The assessment involved a survey of key stakeholders, principally parents, State mental health agency officials, local service providers, and advocates. The survey sought to identify the priorities of State child mental health systems over the next 5 years and the implications of these future directions for the workforce. The survey addressed issues related to recruitment and retention, staff distribution and utilization, staffing requirements for community-based children's services, preservice and inservice training, State capacity to address workforce issues, State-university linkages related to workforce concerns, and change strategies. Study findings include, among others: (1) mental health systems are heading in the direction of more and new types of community-based services, joint initiatives between child mental health and other child-serving systems, and development of new financing mechanisms; (2) new types of community-based services being developed are therapeutic foster care or family treatment homes, in-home services, day treatment programs, therapeutic group homes, intensive case management services, crisis intervention services, respite services, and community-based residential treatment centers; (3) 69 percent of those surveyed considered workforce issues to be at least as important as securing adequate funding; and (4) 71 percent believed that the major reason staff were not adequately prepared was because university curricula are not relevant to State priority areas. The survey instrument is appended. (JDD)

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STAFFING SYSTEMS OF CARE FOR CHILDREN AND FAMILIES:

A Report of the

Southern Human Resource Development Consortium for Mental Health

on

Workforce Issues Related to
Community-Based Service Delivery for
Children and Adolescents with
Serious Emotional Disturbance/Mental Illness
and Their Families

Prepared by:

Sheila A. Pires
HUMAN SERVICE COLLABORATIVE

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November, 1992

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The Southern Human Resource Development Consortium for Mental Health deserves strong recognition for its leadership in addressing workforce issues related to systems of care for children and adolescents with serious emotional disturbance/mental illness and their families. While there has been a focus nationally on human resource development issues related to the delivery of community-based services for adults with serious mental illness, this study, funded by the Consortium, is the first to take an extensive look at workforce issues related to serving children and their families. Sally L. Hein, Ph.D., Executive Director of the Southern HRD Consortium, Ann Patterson, CASSP Project Director for the State of Arkansas and subcommittee chair for this project, and Mardi Carter, Ph.D., Director of the HRD Division of the Mississippi Department of Mental Health and Vice Chair of the Consortium, deserve particular recognition for their support in the formulation and implementation of this study.

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Acknowledgement is due to all of those who participated in the survey -- parents, state agency officials, local providers, advocates and others. They took time out of busy schedules to provide thoughtful, detailed responses to a rather lengthy questionnaire. The level of interest and commitment conveyed by those who responded not only made the study possible, but provides hope for the future of services for children and families.

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Sheila A. Pires

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EXECUTIVE SUMMARY

This report describes the results of a regional needs assessment of workforce issues related to the delivery of community-based services for children and adolescents with serious emotional disturbance/mental illness and their families. The assessment was conducted for the Southern Human Resource Development Consortium for Mental Health, a coalition of 12 southern states, by Human Service Collaborative, a research and consulting group specializing in children's systems, with input from the CASSP Technical Assistance Center at Georgetown University.

Results are based primarily on a survey of key stakeholders in the region, including, principally, parents of children with serious emotional disturbance/mental illness, State mental health agency officials, local service providers and advocates. The survey sought to identify the priorities of State child mental health systems over the next five years and the implications of these future directions for the children's workforce. The survey addressed workforce issues related to recruitment and retention, staff distribution and utilization, staffing requirements for community-based children's services, pre-service and in-service training, State capacity to address workforce issues and State-university linkages related to workforce concerns. The survey also sought to identify strategies in the region to address workforce issues.

The survey was analyzed by region, by each State within the region (except Florida, which did not participate) and by the four major respondent groups (i.e. parents, State mental health agency officials, local providers and advocates).

A. Major Findings

- The major directions in which State child mental health systems in the region are heading over the next five years are:
  - development of more and new types of community-based services (identified by 94% of respondents)
  - joint initiatives between child mental health and other child-serving systems, particularly the child welfare system (identified by 88% of respondents)
  - development of new financing mechanisms (i.e. expansion of Medicaid, use of Title IV-E, blended funding, etc.) (identified by 80% of respondents)
  - development of State and local level coordinating bodies (identified by 71% and 73% of respondents, respectively)
  - development of family advocacy and support programs (identified by 69% of respondents)
  - development of culturally competent services (identified by 65% of respondents).

- The new types of community-based services States are developing are:
  - -- therapeutic foster care or family treatment homes (identified by 82% of respondents)
  - -- in-home services, either crisis or longer term (identified by 78% of respondents)
  - -- day treatment or psychoeducational programs (identified by 73% of respondents)
  - -- therapeutic group homes (identified by 73% of respondents)
  - -- intensive case management services (identified by 69% of respondents)
  - -- crisis intervention services (identified by 67% of respondents)
  - -- respite services (identified by 67% of respondents)
  - -- community-based residential treatment centers (identified by 65% of respondents).

- There is a high level of concern throughout the region over a wide array of workforce issues related to the directions in which States are heading. These include: ability to recruit appropriately trained staff; geographic distribution of staff; racial, ethnic and cultural diversity among staff; staff retention; in-service training; knowledge about staffing requirements; sufficient numbers of staff; and, capacity to assess, address and track workforce issues. The overriding concern is ability to recruit appropriately trained staff. This was ranked as a top three concern by 61% of respondents overall, every State but Texas and all of the major respondent groups. This was the only workforce issue to be ranked in the top three by a majority or more of respondents. Consensus around the next most frequently ranked top three workforce concern drops to 47%; that issue is ability to achieve desired geographic distribution of staff. The third most frequently ranked top three issue (ranked by 22% of respondents) is ability to achieve desired racial, ethnic and cultural diversity among staff.

- 69% of those surveyed consider workforce issues to be at least as important as, or more important than, securing adequate funding to the successful implementation of community-based services for children and adolescents with serious emotional disturbance/mental illness and their families. This was the majority view in every State but Texas and among every major respondent group, except advocates (where there was no majority opinion).

- The majority of respondents regionwide either do not know or do not believe there is adequate knowledge in their respective States about staffing requirements for implementing community-based services for children, including knowledge about the numbers of staff needed, the skills that are required, the types of staff needed, the mix of staff and staff distribution requirements. If knowledge does exist, it is most likely related to identification of required skills; knowledge is least likely to exist in the area of staff distribution (i.e. where and how staff should be deployed). 63% of respondents indicate that their States do not have information available related to staffing requirements that would be useful to other States in the region.

- A large majority (80%) of those surveyed do not believe their States have access to sufficient numbers of staff to implement community-based services for children. Respondents cite a variety of reasons for staff shortages. The top ranked reasons are: insufficient funding to hire staff (ranked as a top three reason by 59% of respondents, all States but Kentucky and all major respondent groups); salaries are too low (ranked by 53%, 8 of 11 States and all respondent groups except advocates); insufficient numbers of persons being trained (ranked by 37%, 6 of 11 States and all respondent groups except parents); and, too few who are trained are entering the public system (ranked by 35%, 7 of 11 States and all respondent groups except parents).

- Those surveyed believe staff shortages exist in every discipline, and types of shortages vary across States. Majority (or greater) consensus as to the most critical shortage areas occurs only with respect to child psychiatry. 73% of respondents, all States but North Carolina and all major respondent groups consider child psychiatry to be the most critical shortage area. Regional consensus as to the next most critical shortage area drops to 20%; those areas are parents in staff roles and psychiatrists. 65% of respondents could identify no strategies in their respective States to address staff shortages.

- A large majority (76%) of those surveyed do not believe their States have access to adequately prepared staff to implement community-based services for children. Respondents believe this is especially a problem in three major areas: working with families (cited by all respondent groups except local providers); understanding emotional disturbance in children and adolescents (cited by all respondent groups except local providers); and, understanding and having the skills to implement the newer community-based service technologies (cited by advocates).

- Respondents believe lack of adequate preparation and training is a problem with all of the disciplines. There was no majority consensus as to which of the disciplines are least adequately prepared. Those most frequently cited are: mental health technicians (cited by 39%); special educators (cited by 36%); and, child psychiatrists (cited by 29%). There also was no consensus as to which of the disciplines are most adequately prepared. Most frequently cited are MSWs and Ph.D. psychologists (by 18%; however 20% also cite MSWs and psychologists as least prepared).

- A large majority (71%) believe that the major reason staff are not adequately prepared is because university curricula are not relevant to State priority areas. This was ranked as a top three reason by all States but South Carolina and all respondent groups. The next most highly ranked reasons are: limited faculty exposure to and understanding of State priority areas (ranked by 65% overall, by 9 States and all of the respondent groups); child mental health system relies on staff from the adult mental health system who are not trained in the children's area (ranked by 41%, 7 States, parents and local providers); and, insufficient opportunities for students to do practica and internships in the public child mental health system (ranked by 41%, 6 States and all respondent groups except parents).

- Respondents rank highly (8-10 on a scale of 1 to 10) the need for in-service training to improve staff skills to implement community-based services for children. The most frequently cited new skills that are needed are: working with families (cited by all respondent groups except local providers); understanding the newer community-based service technologies and the system of care concept (cited by all respondent groups except local providers); interagency competencies (cited by State agency officials and advocates); appropriate use of behavior management (cited by local providers and advocates); and, cultural competency (cited by State agency officials).

- The majority also rank highly (7-10 on a scale of 1-10) the need for in-service training because of inappropriate staff attitudes toward working with children with serious emotional disturbance/mental illness and their families. However, there is greater inconsistency among respondent groups on this issue than with respect to staff skills. 80% of parents rank this a "10" on a scale of 1-10, and 71% of State agency officials, but only 38% of local providers give it this high a ranking. Overall, rankings ranged from 2 to 10, while with respect to staff skills, rankings were between 7 and 10. The areas most frequently cited where staff attitudes are an issue are: working with families (cited by all respondent groups except local providers); resistance to interagency collaboration (cited by State agency officials and advocates); overreliance on hospitalization or traditional, clinic-based psychotherapy (cited by State agency officials and local providers); and, lack of cultural awareness (cited by State agency officials).

- A majority of respondents indicate that appropriate in-service training curricula, methods and personnel are not available in their respective States due, primarily, to lack of funding. Major pieces of curricula are available throughout the region but not necessarily implemented.

- Perceptions as to the extent States are doing in-service training vary considerably by State and by respondent group , as well as within States and respondent groups. However, 61% of respondents overall rank the extent States are conducting in-service training 5 or below on a scale of 1(none) to 10 (extensive).

- With respect to recruitment, respondents indicate that the public child mental health system is most likely to draw staff from: higher education graduating students (respondents estimate, on average, that 37% of children's staff come from this source; cited as the first major source of staff by all States except Oklahoma, which cites the adult mental health system); adult mental health system (estimated to provide 26% of children's staff on average; is a top three source of staff in every State except Kentucky, North Carolina and South Carolina); other public child-serving systems, such as child welfare (estimated to provide 24% of child mental health staff; is a top three source in all States). Staff for the public system are least likely to come from the for-profit sector, higher education faculty and parents.

- Respondents estimate that staff coming from higher education are drawn, roughly, half and half from the Bachelors and Masters levels (each is estimated at about 45%), with the remainder coming from the Associate (11%) and Doctoral (7%) levels. Students predominantly come from in-State, four-year public colleges and universities.

- A solid majority (57%) of those surveyed believe that clinical staff are the most difficult to recruit and that administrative support staff are the least difficult.

- An overwhelming majority (73%) rank child psychiatrists as the most difficult discipline to recruit. Beyond child psychiatry, however, there is no majority consensus as to which are the next most difficult disciplines to recruit. The next most frequently ranked are psychologists, especially at the Doctoral level (ranked by 27%), and psychiatrists (ranked by 20%). There is no majority consensus regarding the disciplines that are the least difficult to recruit. Those most frequently ranked are: social workers at the Bachelors level (ranked by 37%) and mental health technicians (ranked by 24%).

- In-home services was cited most frequently (by 41% of respondents) as the community-based service where States have the most difficulty recruiting staff. This is cited most frequently by 8 States and all respondent groups, except parents, who, for the most part, indicate that they do not know. Clinic outpatient services is most frequently cited (by 33%) as the component where States have the least difficulty recruiting staff.

- In response to the question as to who does recruitment for the public child mental health system, respondents tend to identify a central personnel office in the State mental health agency or in an umbrella human services agency. Those surveyed describe few strengths of their State's recruitment process and a variety of weaknesses, most having to do with a lack of a specialized focus on children's services, bureaucratic obstacles and lack of funding.

- All respondents, but especially parents and advocates, had difficulty answering questions related to recruitment. Few recruitment strategies are identified, most by local providers, which have to do with individual local agency efforts, rather than statewide initiatives.

- Respondents had even greater difficulty answering questions related to retention; again, parents and advocates had the most difficulty, local providers, relatively speaking, the least. Regarding the extent to which retention of children's staff is a problem in the States, the response is inconsistent. Rankings on a scale of 1-low to 10-high range from 2 to 10. Some respondents suggest that the child mental health system is too new for there to be experience with retention issues.

- Those surveyed indicate numerous reasons that staff leave public systems, with no one reason receiving a majority response. They most frequently cite: better salaries (ranked by 49%, 8 States and all respondent groups); more manageable caseloads (ranked by 33%, 4 States, parents and advocates); frustration with the bureaucracy (ranked by 24%, 4 States, local providers and advocates); and, staff feel ineffective with clients because of lack of access to resources (ranked by 24%, 4 States, State agency officials, parents and local providers).

- One of the few questions dealing with retention that received a majority or greater consensus response was with respect to where staff go when they leave public child mental health systems. 53% of respondents say staff go to the private for profit sector, such as a for profit hospital, or into private practice (ranked by 9 States and all respondent groups except parents, who left blank most of the questions related to retention). (The private, for profit sector, however, is not identified as a place from which staff come). The other most frequently cited places where staff go when they leave public child systems are: private non profit sector (ranked by 37%, 6 States , State agency officials and advocates); and, other public child-serving systems, such as child welfare (ranked by 20%, 5 States and local providers).

- A solid majority (61%) of respondents identify clinical staff as the most difficult to retain and administrative support staff and senior managers as the least difficult. (These are also cited as the most and least difficult types of staff to recruit).

- There is majority consensus as to the most difficult discipline to retain only with respect to child psychiatry (ranked by 53%, 8 States and all respondent groups). This is also ranked as the most difficult to recruit. The next most frequently cited disciplines are: psychologists, especially at the Doctoral level (ranked by 29%, 5 States and local providers); psychiatrists (ranked by 20% and local providers); and, social workers (ranked by 20%, parents and State agency officials). Doctoral level psychologists and psychiatrists, like child psychiatrists, also are ranked as most difficult to recruit. Social workers are not ranked as difficult to recruit, however.

- In-home services is cited most frequently as the most difficult service component in which to retain staff (cited by 8 States, State agency officials and local providers). In-home services also is cited as the component where States have the most difficulty recruiting staff. Clinic outpatient services is cited most frequently as the least difficult component in which to retain staff (cited by 5 States, State agency officials and local providers). Clinic outpatient also is cited as the component where States have the least difficulty recruiting staff.

- Few retention strategies are identified, most by local providers, and they pertain to individual local agency efforts, rather than statewide initiatives.

- Those surveyed also had difficulty answering questions related to staff distribution issues. With respect to understaffing concerns, respondents indicate that the types of services where States have the most difficulty recruiting and retaining staff are: crisis services (cited by 8 States and all major respondent groups except parents, who left most questions blank); in-home services (cited by 6 States, State agency officials and local providers); and, therapeutic foster care (cited by 4 States and all major groups except parents). Those surveyed indicate these are difficult components to staff and keep staffed because they tend to be characterized by high levels of stress, irregular hours and schedules, low pay, lack of back-up supports, high caseloads and inadequate training.

- Those surveyed indicate that the service component where States have the least difficulty recruiting and retaining staff is: clinic outpatient services (cited by 8 States and all respondent groups except parents). Respondents believe it is less difficult to recruit and retain staff for this component because it is less stressful, has regular, office-based hours and back-up supports and is most like private practice.

- Those surveyed believe it is most difficult to recruit and retain staff for non traditional service locations, particularly juvenile corrections and child protective services settings, and least difficult to recruit and retain staff for clinic outpatient services.

- Every State in the region cites rural communities as the most geographically understaffed areas.

- Very few strategies are cited to address staff distribution issues, most by local agencies, which pertain to individual agency, not statewide, efforts.

- A large majority (82%) of those surveyed either do not know or indicate there is not a human resource development (HRD) office or other capacity in their respective States focused on the child and adolescent system, although almost half (49%) indicate that there is an HRD office focused on the adult mental health system. An equally large percentage (84%) either do not know or indicate that their States have not had a National Institute of Mental Health grant targeted to workforce issues in the children's system, although about a third (31%) indicate their States have had NIMH grants targeted to adult services. Again, a large majority (88%) either do not know or indicate there is no collaboration between the children's mental health system and their State's HRD office. Respondents in most States cannot identify who is responsible for HRD issues related to the children's system. Over one-third (35%) of State agency officials and one-quarter of local providers say "no one" is responsible.

- Nearly two-thirds (60%) of those surveyed either do not know or indicate there are no linkages between the children's system and higher education in their respective States to address workforce issues. Barriers to State-University linkages are described as lack of time, lack of resource (staff and dollars), lack of leadership and vision on the part of both sectors, and lack of communication and understanding. 80% of parents and 81% of local providers believe there are no linkages or do not know.

B. Observations

In its discussion of survey results, the report draws a number of observations --

- There is a high level of awareness and remarkable consistency across all States and types of respondents about the directions in which States are heading. These new directions represent a major departure in service delivery for children and adolescents with serious emotional disturbance/mental illness and their families, and raise critical workforce issues.

- While all States in the region are moving in similar directions, some are further along than others and/or are engaged on more multiple fronts. This suggests opportunity for peer-to-peer technical assistance among States in the region.

- There exists a high level of concern in every State and among every type of respondent about human resource development (HRD) issues, and this concern covers a wide variety of HRD areas, including; ability to recruit appropriately trained staff; geographic distribution of staff; racial, ethnic and cultural diversity among staff; retention; in-service training; knowledge about staffing requirements; sufficient numbers of staff; and, capacity to assess, address and track HRD issues.

- The HRD issue that generates the greatest degree of consensus is ability to recruit appropriately trained staff. This concern is integrally tied to the perception that university curricula are not relevant to State priority areas, that not enough of those being trained have the requisite knowledge, skills and attitudes and that not enough of those trained are entering public systems. In several States, the issue also is tied to the fact that the child mental health system must rely on staff from the adult system, who do not have the necessary training in children's services.

- Given the lack of capacity in most States to focus on children's workforce issues, and the fact that, in some States, children's systems are at an early developmental stage, it is not surprising that a limited body of knowledge seems to exist with respect to staffing requirements for implementing community-based services. State mental health officials, who are the most aware of what knowledge does exist, are also the most pessimistic about the state of that knowledge, with a very high percentage -- 79%--saying there is not information available in their respective States that would be useful to other States in the region.

- Concern over access to sufficient numbers of staff (regardless of how appropriately trained they are) is, first of all, related to funding issues (insufficient funding to hire staff and low salaries) and, secondly, to training deficits (insufficient numbers being trained and not enough who are trained entering public systems). Those surveyed believe staff shortages exist in every discipline, and the nature of shortages seems to vary considerably from State to State, except for child psychiatrists, who are in short supply in every State, except, apparently, North Carolina. To move beyond speculation, the determination of why types of shortages may vary from State to State requires further exploration, which might also yield information about effective approaches to alleviate shortages.

- Although a majority are concerned, local providers do not express the same degree of concern over issues related to inadequate skills, inappropriate attitudes and inadequate academic preparation as do all of the other major respondent groups. Large majorities (86-100%) of State agency officials, parents and advocates, for example, express concern over States being able to access appropriately trained staff, while 56% of local providers indicate this concern. 100% of parents and State officials believe that university curricula are not relevant to State priority areas, while 56% of local providers share this view. 100% of parents and 71% of State officials believe inappropriate staff attitudes are an issue, while only 38% of local providers have this view. The other respondent groups most frequently cite staff skills and attitudes toward working with families as problem areas, but these are not concerns often cited by local providers. While additional data is needed to understand the reasons for these differences in levels of perception, they are troubling if they suggest that local providers are less in touch with fundamental systems issues. (One reason may be that system of care concepts that have taken several years to develop at State levels are only now beginning to move to local levels).

- Lack of in-service training seems to be related primarily to lack of funding, rather than lack of curricula. While gaps still exist in curricula in some States and some subject areas, major pieces of relevant curricula do exist or are being developed -- such as in the areas of working with families, interagency skill-building, cultural competence, CASSP system of care concepts and many of the new treatment modalities, such as in-home services and intensive case management -- which could be implemented more widely if funding were available.

- Responses related to recruitment and retention indicate a fair amount of staff movement among public child-serving systems, suggesting the usefulness of an interagency approach to HRD issues in the children's area.

- Responses suggest there is only one-way traffic, however, between the public system and the for profit sector. Staff leave public systems to enter the for profit world, including private practice, but there, apparently, is little reciprocity. This raises issues for both sectors -- Are public systems serving as "training grounds" for the for profit sector with little return benefit? How can public systems become more attractive to for profit practitioners? What is the responsibility of the for profit sector to the public system?

- Recruitment and retention responses also suggest that public system staff rarely are drawn from the ranks of higher education faculty, nor do public system staff tend to join faculties when they leave public service. This lack of exchange perpetuates the gap that exists between the public system and higher education.

- The absence of parents in staff roles also is cause for concern. If understanding and working with families is indeed a priority for States, involvement of parents in meaningful staff roles, much like adult systems have begun to involve consumers in staff roles, would help to foster understanding, reduce the isolation that families feel and enhance the skills of providers and parents alike.

- Recruitment, retention and staff distribution responses all suggest a need for HRD strategies targeted to the newer types of services and to non-traditional service locations, which might include pay differentials, specialized training, smaller caseloads, more intensive on-the-job supports and back-up systems, "time off" periods through rotation into other assignments, etc. There also is a need regionwide for strategies targeted to staffing rural areas (and for retaining staff in inner cities); the Community Support Program (CSP) in adult services, which is a decade older than the child and adolescent community-based services movement, may offer examples of strategies adaptable to the children's system.

- Responses suggest that, in most States, there is minimal systematic attention devoted to children's workforce issues, nor is there a structure at State levels to focus on this area beyond the traditional State personnel agency, which most respondents describe as marginally effective at best. The responses of parents, local providers and advocates, who left blank most questions dealing with HRD capacity, suggest that, even where States do have a focus, large groups of key stakeholders do not know about it.

- Respondents strongly believe that universities are not playing a role in encouraging persons to train in child mental health related fields, nor to enter public systems if they do, nor are universities working to ensure that curricula and practica are relevant to public system needs. By the same token, respondents also believe that States are not exerting the leadership to engage and support universities to help meet public sector demands. Even the relatively painless step of establishing a dialogue has not occurred in most States in the region. State-university linkages are critical, and a logical starting point is with public colleges and universities, which, according to respondents, are supplying the majority of staff to public systems and which have a mission to support public concerns.

C. Suggested Next Steps

The report makes a number of recommendations to the Southern HRD Consortium as to next steps it might take to assist States in the region to address workforce issues related to the children's system. These suggestions encourage the Consortium to take a systemic approach to workforce issues --

- The Consortium could play a leadership role in bringing together State and local officials, providers, parents, other key stakeholders and university representatives in the region to highlight child workforce concerns and explore common ground for addressing them. The Consortium could facilitate this dialogue through regional conferences and workshops, as well as "summit meetings" between State mental health commissioners/SMHRCY representatives and key university deans and program chairs.

- The Consortium could embark on a regional public awareness campaign targeted to communities at large and to college campuses to raise consciousness about children with serious emotional disturbance and their families and the opportunities that exist in public systems, particularly those undertaking innovative change. One strategy could be to develop public service announcements, videos, educational material and the like that States within the region could utilize (without each State having to develop its own materials). The CASSP Technical Assistance Center developed similar "generic" public awareness materials for use by States in the early years of CASSP, and the Child Welfare League of America currently is engaged in a similar effort to encourage persons to enter the child welfare field. These are potential resources for the Consortium.

- The Consortium could play a leadership role in convening its counterparts, where they exist, in related children's areas, such as child welfare, to develop coordinated workforce strategies. This could include sponsoring interagency forums between mental health and the child welfare and juvenile justice systems, in particular, to explore incentives that could be offered conjointly to encourage staff to go to and remain in non traditional service locations.

- The Consortium could play a very useful role as facilitator of peer-to-peer technical assistance among States in the region, bringing together States that have developed effective HRD strategies in either the child or adult areas with States that need assistance. The Consortium also could serve as a regional information clearinghouse for effective HRD approaches and materials.

- The Consortium could systematically identify, "package" and disseminate the major pieces of curricula relevant to community-based services for children, and identify where gaps still exist, to save States from having either to track down examples or develop material on their own.

- In addition to the identification and dissemination of curricula, the Consortium could explore other regional approaches to the issue of in-service training needs. Identification of a corps of trainers that States could tap into, perhaps with the Consortium subsidizing some of the costs, is another possibility, particularly if this corps takes a "train the trainers" approach at State levels. Exploring development of a regional training institute, perhaps in collaboration with a coalition of institutions of higher education, is another approach, which, also, of course, could be relevant to issues of pre-service training.

- The Consortium could identify, catalog and disseminate information related to staffing requirements for community-based services and systematically identify the gaps in knowledge that exist in the region. Through targeted workshops, using peer-to-peer and other expert technical assistance, the Consortium could assist individual States in the region to understand their staffing requirements.

- The Consortium, in partnership with regional and/or national families' groups, such as Federation of Families, Alliance for the Mentally Ill-Child and Adolescent Network and State families' organizations, could play a leadership role in ensuring that the family "movement", much like the consumer movement in adult services, becomes an integral part of HRD strategies throughout the region. This would require both consciousness raising, as well as identification and dissemination of effective ways of involving families in the HRD area, such as families assuming paid staff roles, families as teachers in pre and in service training programs, families having roles in public awareness and recruitment campaigns, families serving on taskforces to assess workforce issues, etc.

- The Consortium could form a task force of State and local representatives and parents and give it the charge of identifying for the region effective recruitment and retention strategies for the newer treatment modalities, especially in-home services. The work of the task force could build on a systematic identification of whether other States nationally or systems, such as child welfare, have developed effective strategies in this area.

- The Consortium could play a leadership role in beginning a dialogue with medical colleges, medical societies and professional associations to explore approaches to increasing the numbers of persons entering child psychiatry, which seems to be a critical shortage area in every State but North Carolina.

- The Consortium also could play a leadership role in convening a forum with historic Black colleges and universities in the region to start a process for involving those institutions in training, recruiting and preparing culturally competent staff for public systems.

- Finally, the Consortium could play a leadership role in educating States in the region about the importance of HRD issues to the children's system and assisting States to determine the most effective structures for incorporating an HRD focus in the children's area. The Consortium could begin by bringing together State HRD representatives and SMHRCY representatives to launch a process for achieving mutual understanding and strategies for each State to develop a child HRD capacity.

I. INTRODUCTION

This report describes the results of a regional needs assessment of workforce issues related to the delivery of community-based services for children and adolescents with serious emotional disturbance/mental illness and their families. The study was conducted by Human Service Collaborative (HSC), in partnership with the CASSP Technical Assistance Center, on behalf of the Southern Human Resource Development (HRD) Consortium for Mental Health.

The Southern HRD Consortium for Mental Health is a consortium of twelve southern states, funded by the National Institute of Mental Health (NIMH), to share human resource development information to enhance the delivery of community-based services to adults with serious mental illness and children and adolescents with serious emotional disturbance/mental illness and their families. Those states that are members of the Consortium include: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee and Texas.

The term, "human resource development" (HRD), is defined by NIMH as "the explicit and coordinated efforts of an organization to achieve the right number and right kinds of people in the right places at the right times doing the right things to carry out its mission effectively" (NIMH, 1992). HRD is further defined by NIMH as encompassing a broad set of activities that include: planning and evaluation, i.e. assessing workforce issues as they relate to the mission of an organization, particularly in the context of systems change; workforce management, including recruitment, retention, distribution and utilization of staff; education and training, including both pre-service preparation and in-service training; and, sanctions and regulations, such as standards and licensure.

The results of an HRD needs assessment conducted in late 1990 by the Southern HRD Consortium, which looked at issues relating to services for both adults and children, indicated that service issues and related workforce concerns in the region centered around orientation and training of staff, recruitment and retention of staff and needed staffing patterns for community-based programs and services. During the discussion of these results, members of the Consortium expressed a commitment to examining in greater depth workforce issues related to the delivery of community-based services for children and adolescents with serious emotional disturbance/mental illness and their families. A supplemental grant from NIMH in late 1991 enabled the Consortium to conduct this child/adolescent-focused needs assessment, the results of which are described in this monograph.

II. BACKGROUND

Since the publication of Unclaimed Children in 1982, there has been increasing documentation of the need for improved services for children and adolescents with emotional disorders and their families (Knitzer, 1982; Isaacs, 1984; Behar, 1985; Stroul and Friedman, 1986; Saxe, et. al., 1986; National Mental Health Association, 1989; Pires, 1991). The literature over the last decade emphasizes the importance of a range of community-based services, which is organized into a system of care, coordinated with other child-serving agencies, responsive to cultural and ethnic diversity and family-focused.

Parallelling the literature, important national initiatives were launched over the last decade to encourage and assist state and local jurisdictions to develop community-based systems of care for children and their families --

- In 1984, Congress created the Child and Adolescent Service System Program (CASSP) at NIMH, which has provided funds and technical assistance to all fifty states, U.S. territories and over a dozen local jurisdictions.
- In 1987, the Robert Wood Johnson Foundation began a major child mental health improvement initiative, in which eight states, counties and cities are participating.
- In 1990, Congress amended Public Law 99-660, the State Comprehensive Mental Health Services Plan Act, to require that state plans for establishing and implementing community-based systems of care address the needs of children and adolescents with serious emotional disturbance and their families. Among the major requirements of P.L. 99-660 was that states address the staffing necessary to implement their plans.
- In 1992, the Annie E. Casey Foundation launched its Mental Health Initiative for Urban Children, in which 5 states and cities are participating.
- In 1992, Congress passed legislation to create a new Child Mental Health Services Program to fund community-based services for children and adolescents with emotional disturbance and their families.

Much has been accomplished over the past decade to heighten awareness, articulate a vision and values and define a conceptual framework for a system of care for children and families. The challenge of the '90s is to translate these advances into operational realities. *Workforce issues pose one of the most important challenges to operationalize systems of care for children and their families.*

The implications for the workforce of the developments in the child mental health field over the last decade are enormous --

- The types of less restrictive, community-based services included in most state plans today, such as therapeutic foster care, different types of in-home services, intensive case management, "wraparound" services, respite and crisis services, involve new, still evolving technologies in which the vast majority of staff have not been trained. Indeed, with many of the new technologies, there is continuing experimentation with what staffing patterns ought to look like.

- The interagency collaboration and service integration called for in most state plans today is complex, involving staff from multiple systems with different mandates, financing streams, training and orientation.

- Meaningful involvement of families often requires staff both to acquire new skills and change existing attitudes. Families themselves need training to be effective participants in systems of care, including functioning in staff roles.

- Few staff have been trained in cultural competencies, yet the population is increasingly ethnically and culturally diverse.

- Many state plans encompass both children with serious emotional disorders, as well as those at risk. Staff thus must have the capacity to understand a wide spectrum of disorders, as well as risk factors.

- Many state plans emphasize the importance of early intervention services for infants and toddlers, ages birth to 3, as well as transition services for young adults, ages 18 to 22. Thus, staff capacity must cover a broad developmental range.

- The infrastructure to implement community-based systems of care requires major adjustments in management information systems, financing and other central support structures (including human resource development), which pose challenges for managers and administrative support staff.

- Over the past decade, there has been some formal documentation and much anecdotal corroboration from state and local administrators that academic curricula and practica across all of the disciplines is not keeping pace with developments in public service systems for children and families (Kravitz, 1991). Too often, the academic preparation of those entering child-serving systems has failed to give them the knowledge, skills or attitudes needed to implement effective community-based systems of care.

In addition to this complexity of workforce issues, many states face a far more basic workforce challenge in that they have a gross insufficiency of child and adolescent trained staff (regardless of how appropriately trained they are). Shortages may be limited to certain disciplines, such as child psychiatry, or apply across all areas. They may be limited to certain parts of a state, such as rural areas, or exist statewide. Shortages may be aggravated by limited funding or supply or both. Mandates to redeploy staff from adult components to children's services, particularly staff from downsized state hospitals, may take precedence over the hiring of new child-trained staff.

Assessment of workforce issues is a critical step in the implementation of community-based systems of care. It is crucial to understand a variety of workforce issues, specifically --

- Staffing requirements (i.e. the numbers, mix and skills of staff required for community-based service systems;

- Limitations and strengths of existing staff capacity to implement community-based systems;

- Strengths and weaknesses of academic curricula and practica, as well as in-service training, to provide staff with the required knowledge, skills and attitudes;

- Recruitment, retention and distribution issues; and,

- Similarities in workforce issues nationally and regionally, as well as important differences across States.

With this understanding, States can begin to identify strategies to ensure adequate numbers of appropriately trained staff that are effectively deployed and utilized.

III. METHODOLOGY

The Southern HRD Consortium for Mental Health contracted with Human Service Collaborative in January 1992 to design, develop, analyze and present a regional needs assessment of workforce issues related to the delivery of community-based services for children and adolescents with serious emotional disturbance/mental illness and their families. Human Service Collaborative (HSC) is a research and consulting firm specializing in child and adolescent service systems. HSC conducted the needs assessment in collaboration with the CASSP Technical Assistance Center at Georgetown University.

The principle instrument used for the needs assessment was a written survey. (See Appendix A for a copy of the survey instrument). The survey was designed by HSC, with input from the CASSP Technical Assistance Center, and with feedback and approval from a subcommittee of the Southern HRD Consortium, as well as its Executive Director.

The survey addressed 10 major areas of interest:

Section One related to the goals and objectives of the public mental health system serving children and adolescents and their families in each of the states in the region; this section sought to identify the most important directions in which states wish to head over the next five years.

Section Two related to the major HRD issues associated with the development of community-based services for children and adolescents with serious emotional disturbance/mental illness and their families; this section was intended to provide an overview of the key HRD concerns in each state in the region, as well as an indication of the importance states attach to HRD issues.

Section Three related to staffing requirements; this section sought to shed light on the extent to which states have identified the staffing requirements for implementation of priority areas.

Section Four-Part One related to the question of whether states have access to sufficient numbers of staff, regardless of how appropriately trained they are.

Section Four-Part Two related to the issue of the appropriateness of pre-service training, that is, whether states have access to appropriately trained staff, regardless of whether there are adequate numbers of staff available.

Section Five related to in-service training issues.

Section Six related to recruitment issues.

Section Seven related to retention issues.

Section Eight related to staff distribution and utilization issues.

Section Nine related to the issue of relationships between the child mental health system and HRD offices in each state.

Section Ten related to the issue of linkages between the child mental health system and higher education in each state.

In addition to identifying issues in each of these areas, the survey also sought to identify existing HRD strategies and resources to assist states to address workforce issues.

All of the survey questions addressed themselves to service and HRD issues in the public child mental health system. "Public mental health system" was defined to include both publicly operated programs and services, as well as private programs with which the public sector may contract. Respondents were asked to include in their answers HRD issues affecting both publicly operated programs as well as private agencies providing services on behalf of the public system.

Most survey questions required respondents to check relevant answers from a list and then rank the top three. All sections also included open-ended questions to identify other relevant issues, as well as strategies.

In February 1991, the survey was mailed first class, with a stamped return envelope, to 84 key informants in 11 of the 12 states that are members of the Southern HRD Consortium.* Key informants were identified by State Mental Health Commissioners and HRD managers in each of the states in the region, at the request of the Southern HRD Consortium. Those identified to receive the survey included: parents of children and adolescents with emotional disturbance/mental illness; state mental health commissioners; HRD managers; state mental health representatives for children and youth (SMHRCY); CASSP directors; other state mental health agency officials; local service providers (public and private); state legislators; university representatives; representatives from other child-serving systems, such as child welfare and education; and, state and local advocates. The four largest categories of key informants were: local mental health service providers (public and private); state mental health agency officials; parents; and, advocates.

Copies of the survey also were sent to key individuals at the national level to encourage their interest and assistance in maximizing response to the survey. (See Appendix B for a sample copy of the letter that accompanied the survey, with a list of those individuals at the national level who received copies).

Several rounds of follow-up telephone calls were made to all those who received the survey to ensure receipt and understanding of the survey and to encourage response. Surveys were returned during the period, March-June 1992, and analyzed during June-August 1992.

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*Note: Florida did not participate in the survey.

Survey returns were analyzed to identify the following: 1) central tendencies (pointing to central issues) region-wide; 2) central tendencies by state; 3) central tendencies by four major groups of respondents, which included: state mental health agency officials; local service providers; parents; and, advocates; 4) similarities, if any, in central tendencies between states, as well as between types of respondents; 5) critical differences, if any, in central tendencies between states, as well as between types of respondents (for example, do parents tend to view training needs or service shortage areas differently from state agency officials; are certain states raising critical issues unique to their situations, but not necessarily true region-wide?); and, 6) HRD strategies and resources identified by respondents as effective. "Central tendencies" is defined as those items on the survey checked most frequently by respondents and assigned the highest rankings.

Survey Caveats

In most states in the country, including those in the southern region, there has been minimal systematic data gathering with respect to HRD issues related to services for children and families. It was recognized that those participating in this survey, for the most part, would be offering, at best, their *impressions* of key workforce issues, rather than, necessarily, factual data. Also, given the diversity of the group of key informants participating in the survey, it was not expected that every respondent would be able to answer every question. Respondents were encouraged both to leave questions blank that they did not feel comfortable answering, as well as to offer an opinion even if they felt they did not know "the answer" per se.

Survey results thus convey the impression of key stakeholders with respect to HRD issues, rather than, necessarily, fact. Impressions, of course, particularly those of key stakeholders, are, in themselves, vitally important -- and especially where there is an absence of factual data. Impressions suggest areas where additional data gathering needs to occur. Impressions add weight to fact where the two coincide. Impressions need to be dealt with if the facts differ. The survey results need to be considered in this context.

A second caveat is that not every conceivable type of key stakeholder was represented among the participants. Line workers, for example, were not surveyed, nor were youth, and there are undoubtedly others. Survey results thus represent the impressions of some but by no means all key stakeholders in the region.

The third caveat concerns the variable number of respondents by state and by type of respondent. The number of respondents by state fluctuated from a high of 7 to a low of 1; in other words, as discussed in detail in the next section, as many as 7 individuals responded to the survey from some states and as few as 1 from other states. The number of respondents by the four major groups of respondents fluctuated from a high of 16 to a low of 7 (i.e. 16 local service providers from across the region responded to the survey but only 7 parents). The analysis did not give more or less weight to answers because they represented higher or lower numbers of respondents; for example, it did not give more weight to the answers from local service providers than from parents because more local providers responded, nor did it discount a state because only one individual from the state participated. However, the results should be considered in this context.

IV. SURVEY RESULTS

49 of 84 surveys -- or 58% -- were returned. Table A provides a breakdown of the numbers of respondents by state, and Table B, by type of respondent.

Table A
Breakdown of Respondents by State

Total No. of Respondents: 49

State	No. Sent	No. Returned	Return Rate	% of Total No. of Respondents Regionwide
Alabama	9	4	44%	8%
Arkansas	9	7	78%	14%
Georgia	8	7	88%	14%
Kentucky	2	1	50%	2%
Louisiana	5	2	40%	4%
Mississippi	7	7	100%	14%
N. Carolina	4	3	75%	6%
Oklahoma	6	3	50%	6%
S. Carolina	12	6	50%	12%
Tennessee	11	2	18%	4%
Texas	11	7	64%	14%
TOTAL	**84**	**49**	**58%**	**98%**[**]

[**] Does not equal 100% due to rounding.

Table B
Breakdown of Respondents by Type[*]

Type	Number	% of Total No. of Respondents
Local Mental Health Service Providers - Total	**16**	**33%**
Includes:		
Local Providers (private agency)	9	18%
Local Providers (public agency)	7	14%
State Mental Health Agency Officials - Total	**14**	**29%**
Includes:		
SMHRCY Representatives	6	12%
CASSP Directors	6	12%
State MH Commissioner/Deputy Commissioner	1	2%
State HRD Manager	1	2%
Representatives from State or Local Advocacy Organizations	**12**	**24%**
Parents of a Child or Adolescent with a Serious Emotional Disorder/Mental Illness	**7**	**14%**
Representatives from Another Child Service System such as Education, Child Welfare, Juvenile Justice, etc.	**5**	**10%**
Representatives from Higher Education	**4**	**8%**
State-Level Mental Health Service Provider (e.g., State Hospital)	**3**	**6%**
Representatives of Local Mental Health Governing Board	**3**	**6%**
State or Local Legislator	**1**	**2%**
Representative of Regional HRD Consortium	**1**	**2%**
No Designation	**1**	**2%**

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[*] Respondents categorized themselves by checking the list on the cover of the survey -- see Appendix A. Many respondents checked more than one category; for example, a respondent might have checked both "parent of a child or adolescent with a serious emotional disturbance" and "a representative of a state or local advocacy organization". For this reason, the percentages total more than 100% and the numbers more than the total actual number of respondents.

Section-by-Section Results

Section I Results

Section I relates to the **goals and objectives of the public child mental health system,** including the most important directions in which states wish to head over the next five years.

The most critical objectives of states over the next five years as prioritized by survey respondents are:

- *development of more and new types of community-based services* (identified by 94% of respondents)
- *development of joint initiatives between mental health and other child-serving systems* (identified by 88%)

  NOTE: Those who checked this item identified joint initiatives between mental health and the following agencies:

  child welfare (identified by 80%)
  education (73%)
  juvenile justice (69%)
  substance abuse (61%)
  health (53%)
  runaway and homeless youth programs (27%)

- *new financing mechanisms (e.g. expansion of Medicaid, use of Title IV-E, blended funding, redistribution of inpatient or residential treatment dollars to community-based services, etc.)* (identified by 80%)
- *development of local-level interagency coordinating bodies* (identified by 73%)
- *development of State-level interagency coordinating bodies* (identified by 71%)
- *family support and advocacy programs* (identified by 69%)
- *culturally competent services* (identified by 65%).

Regionwide, the top three new types of community-based services states are reported to be developing or planning to develop are:

- *therapeutic foster care/professional parenting/family treatment homes* (reported by 82% of respondents);
- *in-home services, crisis or longer term* (reported by 78%);
- *day treatment or psychoeducational programs* (reported by 73%); *and,*

- *therapeutic group homes* (reported by 73%).

Other priority services are: intensive case management (reported by 69%); respite services (reported by 67%); crisis intervention (reported by 67%); community-based residential treatment facilities (reported by 65%); therapeutic nursery or day care (reported by 49%); and, supervised independent living for older adolescents (reported by 43%).

By State, the top three new types of community-based services reported are:

State	**Types of Community-Based Services Reported**	**Percent Reporting**
Alabama	Respite services In-home services Community-based residential treatment facilities	75% 75% 75%
Arkansas	In-home services Therapeutic foster care/professional parenting/family treatment homes Therapeutic group homes	100% 100% 100%
Georgia	In-home services Therapeutic group homes Therapeutic foster care/professional parenting/family treatment homes Respite services	100% 100% 100% 100%
Kentucky	In-home services Therapeutic foster care/professional parenting/family treatment homes Respite services Day treatment/psychoeducational programs Community-based residential treatment facilities	100% 100% 100% 100% 100%
Louisiana	In-home services Respite services	100% 100%
Mississippi	Community-based residential treatment facilities Respite services Day treatment/psychoeducational programs	86% 71% 71%
N. Carolina	In-home services Intensive case management Respite services Day treatment/psychoeducational programs Therapeutic group homes	100% 100% 100% 100% 100%

State	Types of Community-Based Services Reported	Percent Reporting
Oklahoma	Therapeutic nursery or day care	100%
	Day treatment/psychoeducational programs	67%
	Therapeutic foster care/professional parenting/family treatment homes	67%
	Therapeutic group homes	67%
	Supervised independent living for older adolescents	67%
S. Carolina	Therapeutic foster care/professional parenting/family treatment homes	100%
	In-home services	100%
	Day treatment/psychoeducational programs	80%
	Crisis intervention	80%
Tennessee	In-home Services	100%
	Therapeutic foster care/professional parenting/family treatment homes	100%
	Intensive case management	100%
Texas	Intensive case management	86%
	Therapeutic foster care/professional parenting/family treatment homes	71%
	Day treatment or psychoeducational programs	71%
	In-home services	71%
	Community-based residential treatment facilities	71%
	Therapeutic group homes	71%
	Crisis intervention	71%

In response to an open-ended question, individual state respondents cited the following as the priority directions in which States are heading --

Alabama:	Interagency collaboration Working with families Increasing public awareness New types of less restrictive, community-based services
Arkansas:	More community-based services Interagency collaboration Increased funding Family support and advocacy Improving the skills of mental health staff

Georgia:	Expansion of community-based continuum More and new financing mechanisms More qualified child and adolescent staff
Kentucky:	Expansion of community-based continuum Family support and advocacy
Louisiana:	Expansion of community-based services that are sensitive to family needs Culturally competent services Local level coordinating bodies
Mississippi:	More community-based services Interagency collaboration New financing mechanisms Family support and advocacy
North Carolina:	Local level interagency coordinating bodies New financing mechanisms Early intervention for birth to 6 year olds Expansion of community-based continuum
Oklahoma:	More community-based services Adequate funding
South Carolina:	More community-based services Interagency collaboration More qualified, appropriately trained child and adolescent staff
Tennessee:	Implementation of the Tennessee Children's Plan (cross agency initiative, targeted to children and adolescents in, or at risk of being placed in, State custody, to reduce restrictive placements and provide individualized services)
Texas:	More and new types of community-based services Family advocacy and support Interagency collaboration New financing mechanisms

Section II Results

Section II relates to the **major HRD issues** associated with the development of community-based services for children and adolescents with serious emotional disturbance/mental illness and their families, and the importance States attach to HRD concerns.

Respondents were asked both to check issues of concern and prioritize the top three. There was no issue that went unchecked, nor was there any issue that did not receive a priority ranking by some number of respondents. Only one issue -- ability to recruit appropriately trained staff -- received a priority ranking by a majority of respondents. The other major issues received top three rankings by smaller percentages of respondents, reflecting different priorities among states and types of respondents.

Regionwide, the top three HRD issues as prioritized by respondents were:

(1) *ability to recruit appropriately trained staff* (ranked among top three issues by 61% of respondents; cited by 10 of 11 States -- all but Texas -- as one of their top three concerns and most often cited as the number one concern; cited by all four major groups of respondents as one of top three concerns and most often cited as the number one concern)

(2) *achievement of the desired distribution of staff geographically* (ranked by 47% of respondents; cited among top three concerns by 7 of 11 States and by all major respondent groups except state agency officials)

(3) *achievement of desired racial, ethnic and cultural diversity among staff* (ranked by 22% of respondents; cited among top three concerns by 5 of 11 States and all major respondent groups except parents).

Other major HRD concerns were prioritized as follows:

- adequate in-service training (ranked in top three by 16% of respondents; cited among top three concerns by 5 of 11 States and one major respondent group -- state mental health agency officials);
- retention of staff (ranked in top three by 16% of respondents; cited among top three concerns by 3 of 11 States but no major respondent group);
- lack of sufficient knowledge about staffing requirements (ranked in top three by 16%; cited among top three concerns by 3 of 11 States and 2 major respondent groups -- local providers and advocates);
- ability to recruit sufficient numbers of staff (ranked in top three by 12% of respondents; cited among top three concerns by 3 of 11 States and by one major respondent group -- parents); and,
- having sufficient capacity in the State to assess, address and track HRD issues (ranked in top three by 10% of respondents; cited among top three concerns by 3 of 11 States but by no major respondent group).

By State and Type of Respondent, the top three HRD concerns were prioritized as follows:

Respondent	Appropriately Trained Staff	Geographic Distribution of Staff	Racial, Cultural & Ethnic Diversity	In-Service Training	Retention	Knowledge About Staffing Requirements	Sufficient Nos. of Staff	HRD Capacity	Other
By State:									
Alabama	50%	25%		25%			50%	25%	
Arkansas	57%	57%				57%			
Georgia	86%	57%			43%				
Kentucky	100%			100%			100%		
Louisiana	50%		50%	50%			50%		50%*
Mississippi	57%	57%			43%				
N. Carolina	100%		67%	67%					
Oklahoma	67%	67%	67%						
S. Carolina	60%	60%	40%		40%				
Tennessee	100%					100%		100%	
Texas		71%	57%	29%		29%		29%	
Respondent Groups:									
Parents	43%	43%					57%		
State Officials	71%		57%	64%					
Local Providers	75%	50%	25%			25%			
Advocates	60%	60%	40%			40%			

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* "Staff at all levels need to have the philosophy or belief that community-based services can work with and for children and adolescents who have serious emotional disturbance and their families."

With respect to gauging the importance respondents attach to HRD issues, respondents were asked to compare HRD concerns with that of securing adequate funding for community-based services.

Regionwide, *61% of respondents view HRD issues to be "as critical as" securing adequate funding.* This was the majority response in 8 of 11 States. In only one State, Texas, did respondents consider HRD issues as less critical than securing adequate funding. In two States, there was no majority response. "As critical as funding" was also the majority response among all major respondent groups except advocates, where there was no majority response.

The breakdown was:

Respondent	As Critical As	More Critical Than	Less Critical Than	No Opinion-Left Blank
Regionwide	61%	8%	20%	11%
By State: Alabama	25%	25%	25%	25%
Arkansas	57%	14%	14%	14%
Georgia	71%		29%	
Kentucky	100%			
Louisiana	50%		50%	
Mississippi	86%		14%	
N. Carolina	100%			
Oklahoma	67%		33%	
S. Carolina	80%	20%		
Tennessee	100%			
Texas	14%	14%	57%	14%
Respondent Groups: Parents	43%	29%	29%	
State Officials	71%	7%	21%	
Local Providers	79%	8%	13%	
Advocates	40%		40%	20%

Section III Results

Section III relates to knowledge about **staffing requirements.** For example, if a State has identified intensive case management services as a priority area, has the State identified how many staff are needed and what types, the skills that are required, the mix of staff and desired distribution?

Respondents, in general, had difficulty answering the questions in this section as reflected by the numbers of answers left blank and the fact that most answers do not reflect a majority opinion. Also, there were a significant number of comments from respondents to the effect that it was difficult for them to answer the questions. *The responses do indicate, however, that the majority of respondents do not think there is, or do not know if there is, adequate knowledge in their respective States about staffing requirements related to community-based services for children.*

The following answers were provided to the question, "Is there sufficient knowledge in your State about" --

Regionwide		
Number of Staff Needed	yes no left blank	37% 49% 14%
Skills required	yes no left blank	43% 41% 16%
Types of staff needed	yes no left blank	39% 45% 16%
Mix of staff	yes no left blank	31% 51% 18%
Distribution of staff	yes no left blank	27% 57% 16%

By State, responses were as follows --

Alabama		
Number of Staff Needed	yes no left blank	50% 25% 25%
Skills required	yes no left blank	25% 50% 25%
Types of staff needed	yes no left blank	50% 25% 25%
Mix of staff	yes no left blank	50% 25% 25%
Distribution of staff	yes no left blank	25% 50% 25%

Arkansas		
Number of Staff Needed	yes no left blank	29% 71%
Skills required	yes no left blank	29% 57% 14%
Types of staff needed	yes no left blank	29% 57% 14%
Mix of staff	yes no left blank	14% 71% 14%
Distribution of staff	yes no left blank	29% 57% 14%

Georgia		
Number of Staff Needed	yes	43%
	no	57%
Skills required	yes	43%
	no	57%
Types of staff needed	yes	43%
	no	57%
Mix of staff	yes	43%
	no	43%
	left blank	14%
Distribution of staff	yes	29%
	no	71%

Kentucky		
Number of Staff Needed	yes	100%
Skills required	yes	100%
Types of staff needed	yes	100%
Mix of staff	yes	100%
Distribution of staff	no	100%

Louisiana		
Number of Staff Needed	no	100%
Skills required	yes	50%
	no	50%
Types of staff needed	no	100%
Mix of staff	no	100%
Distribution of staff	no	100%

Mississippi

Number of Staff Needed	yes	57%
	no	29%
	left blank	14%
Skills required	yes	43%
	no	43%
	left blank	14%
Types of staff needed	yes	57%
	no	29%
	left blank	14%
Mix of staff	yes	29%
	no	57%
	left blank	14%
Distribution of staff	yes	29%
	no	57%
	left blank	14%

North Carolina

100% of respondents indicate that the State does have sufficient knowledge about staffing requirements, except in some very specialized areas, such as treatment programs for sexual offenders.

Oklahoma

Number of Staff Needed	yes	33%
	no	67%
Skills required	yes	67%
	no	33%
Types of staff needed	yes	33%
	no	67%
Mix of staff	yes	33%
	no	67%
Distribution of staff	yes	33%
	no	67%

South Carolina		
Note: There are several "40/40" splits in South Carolina answers, which represent State agency respondents answering "no" and local service providers answering "yes" to the same questions.		
Number of Staff Needed	yes no left blank	40% 40% 20%
Skills required	yes no left blank	60% 20% 20%
Types of staff needed	yes no left blank	60% 20% 20%
Mix of staff	yes no left blank	40% 40% 20%
Distribution of staff	yes no left blank	40% 40% 20%

Tennessee
50% of Tennessee respondents left all answers blank. The other 50% said "no" to all questions.

Texas		
Number of Staff Needed	yes	14%
	no	43%
	left blank	43%
Skills required	yes	43%
	no	14%
	left blank	43%
Types of staff needed	yes	14%
	no	43%
	left blank	43%
Mix of staff	yes	14%
	no	43%
	left blank	43%
Distribution of staff	yes	14%
	no	43%
	left blank	43%

Major Respondent Groups provided the following answers regarding knowledge of staffing requirements --

Parents		
Number of Staff Needed	yes	43%
	no	29%
	left blank	29%
Skills required	yes	29%
	no	43%
	left blank	29%
Types of staff needed	yes	29%
	no	43%
	left blank	29%
Mix of staff	yes	43%
	no	29%
	left blank	29%
Distribution of staff	yes	29%
	no	43%
	left blank	29%

State Agency Officials		
Number of Staff Needed	yes	36%
	no	64%
Skills required	yes	50%
	no	50%
Types of staff needed	yes	50%
	no	50%
Mix of staff	yes	29%
	no	71%
Distribution of staff	yes	21%
	no	79%

Local Service Providers		
Number of Staff Needed	yes	38%
	no	50%
	left blank	12%
Skills required	yes	56%
	no	38%
	left blank	6%
Types of staff needed	yes	38%
	no	44%
	left blank	18%
Mix of staff	yes	38%
	no	50%
	left blank	12%
Distribution of staff	yes	38%
	no	50%
	left blank	12%

Advocates		
Number of Staff Needed	yes	40%
	no	20%
	left blank	40%
Skills required	no	60%
	left blank	40%
Types of staff needed	yes	20%
	no	20%
	left blank	60%
Mix of staff	no	20%
	left blank	80%
Distribution of staff	no	40%
	left blank	60%

Responses to the question regarding whether or not a particular State has information on staffing requirements that would be useful to other States in the region were as follows --

Respondent	Has Useful Information			Additional Comments
	Yes	No	Blank	
Regionwide	20%	63%	16%	
By State: Alabama	25%	50%	25%	No specific information was identified
Arkansas		71%	29%	
Georgia	29%	29%	43%	No specific information was identified, but the State plan is described as a model that may be useful to others
Kentucky	100%			Information is available through Kentucky IMPACT, Kentucky's Robert Wood Johnson Foundation child mental health project, on the staffing requirements for case management, intensive in-home services, wraparound services aides and therapeutic foster care.
Louisiana		100%		
Mississippi	29%	57%	14%	No specific information was identified except State minimum standards
North Carolina	67%			The State plan, the State child and adolescent mental health director and selected local area programs are indicated for follow-up
Oklahoma	33%	67%		No specific information was indicated
South Carolina		100%		
Tennessee		50%	50%	
Texas	14%	43%	43%	No specific information was indicated
Major Groups: Parents	29%	29%	43%	
State Officials	21%	79%		
Local Providers	24%	38%	38%	
Advocates		60%	40%	

Section IV- Part One Results

Section IV-Part One relates to the issue of whether States have access to **sufficient numbers of staff**, regardless of whether they are appropriately trained or not.

Regionwide, *80% of respondents believe that States do not have access to sufficient numbers of staff to implement priority areas for delivering community-based services for children and adolescents with serious emotional disturbance/mental illness and their families.* This was the majority response in 9 of 11 States (not in North Carolina or Texas) and by all four major respondent groups.

Respondents were asked both to check shortage areas and prioritize the top three. There was no discipline that went unchecked or unranked by some number of respondents. However, the only discipline ranked as a top three shortage area by a majority of respondents was child psychiatry. After that, rankings varied by State and type of respondent, as described below.

The top three shortage areas by discipline or type of staff were identified as follows:

(1) *Child psychiatrists* (ranked in top three by 73% of respondents regionwide; this was among the top three answers in every State except North Carolina and among the four major respondent groups).

(2) *Parents in staff roles* and *psychiatrists* tied for second (each ranked in the top three by 20% of respondents regionwide).

(3) *Staff of color,* particularly professional staff (ranked in the top three by 18% of respondents).

Tied for fourth (each ranked in the top three by 16% of respondents) were psychologists, particularly Ph.D. level, and special educators trained in working with children and adolescents with serious emotional disturbance/mental illness and their families.

The three major reasons for staff shortages were prioritized as follows (Note: There was majority ranking for the first two described below; after that, there was variation among states and by type of respondent):

(1) *Insufficient funding to hire staff* (ranked in top three by 59% of respondents; was among the top three reasons cited in every State except Kentucky and by all four respondent groups).

(2) *Salaries too low* (ranked in top three by 53% of respondents; cited as one of the top three reasons by 8 of 11 States -- not in Louisiana, North Carolina or Tennessee -- and by all respondent groups except advocates).

(3) *Insufficient numbers of persons being trained* (ranked in top three by 37% of respondents; among top three reasons in 6 of 11 States and cited by all major respondent groups except parents).

A close fourth, ranked in top three by 35% of respondents and by 7 of 11 States and all respondent groups except parents, was "too few who are trained enter the public system".

Most States and most major groups of respondents (65% of respondents overall) could identify no strategies to alleviate staff shortages. Those that were identified are described in Figure 3 by State and respondent groups.

Figure 3 - Three Major Staff Shortage Areas and the Major Reasons for Shortages

Respondent	Access to Sufficient # Staff Overall	Critical Shortage Areas (% ranking)	Reasons (% ranking)	Strategies to Alleviate Shortages
By State:				
Alabama	100% - no	Child Psychiatrists (50%) Special Educators (50%) Adjunctive Therapists (50%)	Insufficient funding (100%) Salaries too low (100%) Lack of advancement opportunities (100%)	Advocacy to obtain more funding.
Arkansas	86% - no	Child Psychiatrists (57%) Parents in Staff Roles (57%) Social Workers - MSW (43%)	Insufficient number of persons being trained (71%) Insufficient funding to hire staff (57%) Salaries too low (57%)	• Advocacy to obtain more funding. • Task forces involving all key stakeholders, including university representatives, parents, local providers and state agency reps. • Arrangement between CMHC and university medical school to have 4th year residents do rotation in rural CMHC.
Georgia	71% - no	Child Psychiatrists (86%) Psychiatrists (57%) Parents in Staff Roles (43%)	Insufficient funding to hire staff (71%) Too few entering public system (57%) Salaries too low **and** Poor recruitment system (43% each)	• Serve more Medicaid-eligible children to generate more revenue in order to hire more staff • Advocacy to increase funding; "Hope and pray, no kidding!"
Kentucky	100% - no	Child Psychiatrists (100%) Adjunctive Therapists (100%) Paraprofessionals (100%)	Salaries too low (100%) Too few entering public system (100%) Undesirable geographic area (100%)	None indicated.
Louisiana	100% - no	Child Psychiatrists (100%) Staff of Color (100%) Psychologists (100%)[1]	Too few entering public system (100%) Insufficient funding to hire staff (50%) Undesirable service locations (50%) Insufficient number being trained (50%) "Rigidity of system" (50%)	Expand Medicaid through use of the rehabilitation services option to generate more revenue to be able to hire more staff.

Respondent	Access to Sufficient # Staff Overall	Critical Shortage Areas (% ranking)	Reasons (% ranking)	Strategies to Alleviate Shortages
Mississippi	100% - no	Child Psychiatrists (71%) Psychiatrists (43%) Psychologists (43%) Parents in Staff Roles (43%) Adjunctive Therapists (43%) Psychiatric Nurses (43%)	Salaries too low (86%) Insufficient funding to hire staff (57%) Not enough persons being trained (29%)	None indicated.
North Carolina	67% - yes	Special Educators (67%)[2]	Too few being trained (100%) Too few entering public system (100%)	• NIMH HRD grant to train persons of color, families, consumers and natural helpers to meet CMHC requirements for employment and advancement. • State takes a lead role in developing curricula at the B.A. and Masters level and to work with universities to expose students to community programs.
Oklahoma	67% - no	Child Psychiatrists (67%) Psychiatrists (67%)	Insufficient funding to hire staff (100%) Salaries too low (100%)	None indicated.
South Carolina	100% - no	Child Psychiatrists (100%) Staff of Color (80%) Psychologists (60%)	Insufficient funding to hire staff (80%) Not enough persons being trained (60%) Salaries too low (60%)	Formation of S.C. Public-Academic Mental Health Consortium, including S.C. universities and colleges and State mental health system, to develop common agenda.
Tennessee	100% - no	Child Psychiatrists (100%)	Not enough persons being trained (100%) Insufficient funding to hire staff (50%) Undesirable geographic (rural) area (50%) "Public child mental health system is not a priority for professionals in the field" (50%)	None indicated.
Texas	43% - yes 29% - no 29% - blank	Child Psychiatrists (57%) Staff of Color (43%) Special Educators (43%)	Too few entering the public system (43%) Not enough persons being trained (43%) Insufficient funding to hire staff (29%) Salaries too low (29%)	Advocacy to increase salaries.

Respondent	Access to Sufficient # Staff Overall	Critical Shortage Areas (% ranking)	Reasons (% ranking)	Strategies to Alleviate Shortages
Major Respondent Groups:				
Parents	100% - no	Child Psychiatrists (43%) Parents in Staff roles (43%) Adjunctive Therapists (29%)	Salaries too low (57%) Insufficient funding to hire staff (29%) Undesirable geographic area (14%) Lack of advancement opportunity (14%)	71% of parents could identify no strategies.
State Agency Officials	93% - no[3]	Child Psychiatrists (57%) Staff of Color (36%) Psychologists (29%) Special Educators (29%) Parents in Staff Roles (29%)	Salaries too low (64%) Not enough persons being trained (50%) Too few entering public system (36%) Insufficient funding to hire staff (36%)	64% of State agency officials could identify no strategies.
Local Service Providers	75% - no	Child Psychiatrists (75%) Psychiatrists (50%) Psychologists (44%)	Insufficient funding to hire staff (75%) Too few entering the public system (44%) Poor recruitment system (44%)	86% of local providers could identify no strategies.
Advocates	60% - no 40% - yes* (*in urban, not rural, areas)	Child Psychiatrists (100%) Special Educators (40%) Staff of Color (40%) Psychiatric Nurses (40%)	Not enough persons being trained (100%) Too few entering public system (80%) Insufficient funding to hire staff (60%)	80% of advocates could identify no strategies.

Notes:

1. One respondent also commented that "in shifting to a less medically driven, community-based model, the skills and orientation of workers are now more important than training background (i.e., discipline)."

2. This was the only consistent response. Other shortage areas identified, but with no consistency, were: psychologists at the Ph.D. level, staff of color with advanced training and nurses.

3. Every State agency official, except in North Carolina, said "no".

Section IV-Part Two Results

Section IV-Part Two relates to the **adequacy of pre-service training;** it addresses the issue of whether States have access to appropriately trained staff to implement priority areas, regardless of whether there are sufficient numbers of staff.

Regionwide, *76% of respondents indicated that their respective States do not have access to appropriately trained staff to deliver community-based services for children and adolescents with serious emotional disturbance/mental illness and their families.* This was the majority response in every State, except Tennessee where the two respondents split, with the higher education representative saying "yes" and the advocate saying "no". It was also the majority response by all major groups of respondents.

In response to open-ended questions regarding areas where lack of adequate preparation and training is especially a problem, respondents **regionwide** identified the following most frequently:

(1) *Working with families* (cited by 7 of 11 States and by all major respondent groups except local providers)

(2) *Understanding child development and emotional disturbance in children and adolescents* (cited by 5 of 11 States and by all major respondent groups except local providers)

(3) *Understanding new community-based service technologies* (cited by 5 of 11 States and one major respondent group - advocates).

There was no majority opinion as to which disciplines or categories of staff pose the greatest problem in terms of lack of adequate preparation; responses varied by State and type of respondent. The following disciplines or categories of staff emerged as the top three most frequently cited **regionwide** as lacking adequate preparation --

(1) *Mental health technicians* (cited by 39% of respondents; was among top three cited by 6 of 11 States and all four major respondent groups)

(2) *Special educators* (cited by 36% of respondents; among top three by 6 of 11 States and all major respondent groups except local providers)

(3) Tie between: *child psychiatrists* and *paraprofessionals* (cited by 29% of respondents; among top three by 4 of 11 States, parents and local provider groups)

In response to an open-ended question as to which disciplines posed the least problem in terms of adequate preparation, most often cited were *social workers* and *psychologists* (cited by 18% each). (However, 20% of respondents also put social workers and psychologists in the category of posing the most problem.) In general, answers varied widely by State, and many respondents left this question blank.

Regionwide, respondents identified the following as the top three reasons for staff not being adequately prepared:

(1) *University curricula are not relevant to State priority areas* (cited by 71% of respondents; among top three answers in all States except South Carolina and by all major respondent groups)

(2) *Limited faculty exposure to and understanding of State priority areas* (cited by 65% of respondents; among top three answers in 9 of 11 States and among all major respondent groups)

(3) *Child mental health system relies on staff from the adult mental health system who are not trained in the children's area* (cited by 41% of respondents; among top three answers in 7 of 11 States, parents and local providers)

tied with

Insufficient opportunities for students to do practica and internships in the public mental health system (cited by 41% of respondents; among top three answers in 6 of 11 States and all major respondent groups except parents).

By State, the following answers were provided with respect to appropriateness of training:

Alabama		
Access to Appropriately Trained Staff Overall?		No 100%
Priority Problem Areas:	• Working with families • Working with children with serious emotional disturbance and their families in community-based (as opposed to hospital) settings • How to do treatment planning	
Most Problematic by Discipline:	Special Educators Child Psychiatrists Psychiatrists MSWs Mental Health Technicians	100% 50% 50% 50% 50%
Reasons for Inadequate Preparation:	• University curricula are not relevant: "Curricula are not based on 'real life'; does not include 'hands on' experience; interagency lack of communication; universities are out of touch; does not address family issues; does not include a focus on children with serious emotional disturbance; is not interdisciplinary"	100%
	• Insufficient opportunities for students to do practica and internships in the public child mental health system	100%
	• Limited faculty exposure to State priority areas	50%
	• University or accrediting body administrative barriers to developing relevant curricula	50%
	• Reliance on staff from the adult system	50%
	• Reliance on paraprofessionals who do not receive adequate pre-service training	50%
Strategies:	None indicated	

Arkansas		
Access to Appropriately Trained Staff Overall?		No 71%
Priority Problem Areas:	• Working with parents • Understanding emotional disturbance in children • How to distinguish between emotional disorders and behavioral problems and how to deal with both • Cultural competency	
Most Problematic by Discipline:	Child Psychiatrists	71%
	Special Educators	71%
	Social Workers - B.A.	71%
	Mental Health Technicians	71%
	Paraprofessionals	71%
	Parents in Staff Roles	71%
Reasons for Inadequate Preparation:	• University curricula are not relevant: "Curricula are too clinic-based; community-based services are not a priority; curricula need to incorporate more practical experience"	71%
	• Limited faculty exposure to State priority areas	71%
	• Reliance on staff from the adult system	57%
Strategies:	• Linkages with higher education to develop priority on training in community-based services • Some universities and nursing schools incorporate Arkansas Alliance for the Mentally Ill awareness training in which family members talk to classes, and students must attend an AAMI support meeting, learn about family issues and what resources are and are not available in the community.	

Georgia		
Access to Appropriately Trained Staff Overall?		No 86%
Priority Problem Areas:	• Working with families • Understanding emotional disturbance in children • Understanding new community-based service technologies, such as therapeutic foster care, crisis intervention • Interagency skills • How to translate theory into practice • "Clinical skills which recognize the limitations of the system and allow for flexibility in treatment and coordination of treatment"	
Most Problematic by Discipline:	Mental Health Technicians Paraprofessionals Social Workers - MSW and B.A. level	86% 71% 71%
Reasons for Inadequate Preparation:	• Limited faculty exposure to State priority areas • University curricula are not relevant: "No hands-on experience; teaches 'talking therapies' only; fails to train staff in realities of working with children with serious emotional disorders; does not help students move away from private practice model; does not reflect new research on mental illness; still blames the family" • Reliance on paraprofessionals	100% 86% 71%
Strategies:	Preliminary planning with the University of Georgia to strengthen state agency-academic ties, specifically through contracting with the university to do evaluative research and develop practicum experiences in the State's new core community-based services program	

Kentucky		
Access to Appropriately Trained Staff Overall?		No 100%
Priority Problem Areas:	• Working with families • Understanding new community-based service technologies • Interagency skills	
Most Problematic by Discipline:	Special Educators Mental Health Technicians Paraprofessionals Case Managers/Service Coordinators regardless of discipline	100% 100% 100% 100%
Reasons for Inadequate Preparation:	• University curricula are not relevant: "Theory not practice; need to shift to interdisciplinary philosophy" • Limited faculty exposure to State priority areas • System relies on paraprofessionals	100% 100% 100%
Strategies:	• Grant applications to the U.S. Department of Education to pilot curriculum changes • One-to-one work with university staff re: interagency process • Expansion of training focus to include paraprofessional staff	

Louisiana		
Access to Appropriately Trained Staff Overall?		No 100%
Priority Problem Areas:	• Interagency skills • Orientation away from private practice	
Most Problematic by Discipline:	Special Educators Child Psychiatrists Psychiatrists Psychologists	100% 50% 50% 50%
Reasons for Inadequate Preparation:	• University curricula are not relevant: "Curricula still aim more toward the private practitioner who will deal mainly with middle class and up values or adults with chronic mental illness" • Insufficient opportunities to do practica in public system • Reliance on staff from adult system	100% 100% 100%
Strategies:	Local interagency training with parents	

Mississippi		
Access to Appropriately Trained Staff Overall?		No 57%
Priority Problem Areas:	• Understanding child development • Working with families • Interagency skills • Appropriate use of behavior management • Understanding of child welfare issues	
Most Problematic by Discipline:	Mental Health Technicians Psychologists Special Educators Child Psychiatrists Paraprofessionals	57% 57% 43% 43% 43%
Reasons for Inadequate Preparation:	• University curricula are not relevant: "Special educators are not trained in specific disabilities or in behavior management; there is a great need for regular educators to be trained also; no concentration on children with serious emotional disturbance and their families; too theoretical; in social work, curricula are weak in child welfare issues, heavy on policy and research"	86%
	• Insufficient opportunities to do practica in public system	57%
	• Limited faculty exposure to State priority areas	57%
	• Reliance on staff from adult system	57%
	• Reliance on paraprofessionals	57%
Strategies:	Nothing specified	

North Carolina		
Access to Appropriately Trained Staff Overall?		No 100%
Priority Problem Areas:	• "All areas except traditional office-based psychotherapy" • New community-based service technologies, especially family preservation, clinic case management, early intervention from birth to four years old and treatment for sexual offenders. • Understanding of early childhood development • Problems of children with substance abusing parents	
Most Problematic by Discipline:	Child Psychiatrists Psychologists Nurses Psychiatrists MSWs	100% 67% 67% 67% 67%
Reasons for Inadequate Preparation:	• University curricula are not relevant: "Too great a focus on office-based psychotherapy" • Limited faculty exposure to State priority areas • Limited opportunities for practica in the public system	100% 100% 100%
Strategies:	State funds CMHC to work with University of North Carolina-Chapel Hill to involve students from Departments of Psychology and Psychiatry and Schools of Nursing and Social Work to intern at CMHC in all program components, except office-based psychotherapy	

Oklahoma		
Access to Appropriately Trained Staff Overall?		No 67%
Priority Problem Areas:	• Knowledge of minority and low income populations • Clinical training and professional ethics	
Most Problematic by Discipline:	Psychiatrists Nurses Parents in Staff Roles	100% 100% 100%
Reasons for Inadequate Preparation:	• University curricula are not relevant • Reliance on staff from adult system	100% 100%
Strategies:	Nothing specific except state standards for some community-based services and some training workshops	

South Carolina		
Access to Appropriately Trained Staff Overall?		No 80%
Priority Problem Areas:	• Working with families • Cultural competency • Crisis intervention skills • Understanding emotional disturbance in children	
Most Problematic by Discipline:	Psychiatrists "Can be in any discipline" - little consistency in responses	40%
Reasons for Inadequate Preparation:	• Limited faculty exposure to State priority areas • Insufficient opportunities to do practica in public system • Reliance on staff from adult system	60% 60% 60%
Strategies:	• Development of S.C. Public-Academic Mental Health Consortium	

Tennessee		
Access to Appropriately Trained Staff Overall?		50/50 split[*]
Priority Problem Areas:	New Community-based service technologies, especially intensive case management and in-home services	
Most Problematic by Discipline:	Mental Health Technicians Social Workers	50% 50%
Reasons for Inadequate Preparation:	• Limited faculty exposure to State priority areas • University curricula are not relevant: "Curricula continue to focus on traditional models; not enough focus on policy-related issues that are influencing service delivery" • Reliance on staff from adult system • Reliance on paraprofessionals	100% 50% 50% 50%
Strategies:	"Discussed in detail in the adult area but children's area not given much attention"	

Texas		
Access to Appropriately Trained Staff Overall?		No 57%
Priority Problem Areas:	• Training in new modalities that are not office-based • Assessment and treatment planning skills • Community-based service technologies, especially day treatment and in-home services	
Most Problematic by Discipline:	Special Educators (only consistent response)	43%
Reasons for Inadequate Preparation:	• Limited faculty exposure to State priority areas • Limited opportunities to do practica in public systems • University curricula are not relevant: "Curricula lead to preparing practitioners in traditional outpatient modalities"	57% 43% 43%
Strategies:	None specified	

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[*] Advocate says "no"; higher education representative says "yes".

Major groups of respondents provided the following impressions with respect to appropriateness of pre-service training --

Parents		
Access to Appropriately Trained Staff Overall?		No 100%
Priority Problem Areas:	• Attitudes toward families ("staff are unrealistic, are not aware of the severe stress placed on families with a mentally ill child") • Distinguishing between emotional disorders and behavioral problems • Understanding how to provide holistic services	
Most Problematic by Discipline:	No consistency -- all disciplines checked	
Reasons for Inadequate Preparation:	• University curricula are not relevant: "Curricula still blame the family" • Limited faculty exposure to State priority areas • University or accrediting body administrative barriers to developing relevant curricula • Reliance on staff from adult system	100% 100% 100% 100%
Strategies:	None specified	

State Agency Officials		
Access to Appropriately Trained Staff Overall?		No 86%
Priority Problem Areas:	• Working with families • Understanding emotional disturbance in children	
Most Problematic by Discipline:	Special Educators Psychiatrists Mental Health Technicians	64% 57% 57%
Reasons for Inadequate Preparation:	• University curricula are not relevant: "Emphasis is on traditional psychotherapy; no focus on children with emotional disturbance and their families; too theoretical" • Limited faculty exposure to State priority areas • Insufficient opportunity to do practica in public system	100% 93% 79%
Strategies:	None specified	

Local Service Providers		
Access to Appropriately Trained Staff Overall?		No 56%
Priority Problem Areas:	• Distinguishing between emotional disorders and behavioral problems • Assessment and treatment planning skills	
Most Problematic by Discipline:	Child Psychiatrists Psychiatrists Mental Health Technicians	44% 44% 44%
Reasons for Inadequate Preparation:	• Limited faculty exposure to State priority areas • University curricula are not relevant: "No hands-on experience; lack of focus on new community-based service technologies" • Insufficient opportunities to do practica in public systems • Reliance on staff from adult system	63% 56% 56% 56%
Strategies:	None specified	

Advocates		
Access to Appropriately Trained Staff Overall?		No 100%
Priority Problem Areas:	• Understanding new community-based service technologies • Understanding emotional disturbance in children • Understanding family needs	
Most Problematic by Discipline:	Psychologists Special Educators Mental Health Technicians Social Workers - Masters and B.A. level	80% 80% 80% 80%
Reasons for Inadequate Preparation:	• University curricula are not relevant: "Focuses on old models; teaches 'talking therapies' only; fails to train staff in realities of working with seriously emotionally disturbed children; lacks practical experience; not up-to-date; not specific to needs of children and families; not intensive enough" • Limited exposure of State priority areas • Insufficient opportunities to do practica in public system	100% 100% 80%
Strategies:	None specified	

Section V Results

Section V relates to the issue of **in-service training.**

Respondents were asked to rank, on a scale of 1-low to 10-high, the need for in-service training to ensure appropriate staff skills to implement State priority areas related to community-based services for children and adolescents with serious emotional disturbance/mental illness and their families. **Regionwide,** the lowest ranking was a 7 and the highest, 10. There was a consistent range of 8-10 across all States, except Mississippi, where the range was 7-10. Parents consistently ranked the need for in-service training a 10. Local service providers and advocates ranked the need 8-10, and state agency officials, 7-10.

Asked, in an open-ended question, to identify the three most important new skills staff need to have, respondents **regionwide** identified the following most frequently:

(1) *Working with families:* cited by respondents in 7 of 11 states and by all major groups of respondents except local service providers

(2) *Understanding new community-based treatment modalities and the system of care concept:* cited by respondents in 5 of 11 States and by all major groups of respondents except local service providers

(3) *Interagency skills:* cited by respondents in 5 of 11 States and by two major respondent groups - state agency officials and advocates

tied with

Understanding emotional disturbance in children and how to distinguish between emotional disorders and behavioral problems: cited by respondents in 5 of 11 States and by two major groups of respondents - local service providers and advocates.

Respondents were asked to rank, on a scale of 1=low to 10=high, the need for in-service training because staff have inappropriate skills and attitudes for working with children with serious emotional disturbance/mental illness and their families. The largest single percentage of respondents (26%) assigned a 10 to this area; however, there was wide variance, with a range of 10 to 2. 100% of parents ranked this a 10 and 71% of State agency officials. However, only 38% of local service providers gave this a 10, and advocates ranged from 3 to 10.

Regionwide, respondents identified the following as the major areas where staff display inappropriate skills and attitudes --

(1) *Attitudes towards families, such as blaming families:* cited by respondents in 8 of 11 States and by all major groups of respondents except local service providers

(2) *Resistance to interagency collaboration:* cited by respondents in 4 of 11 States and by two groups of respondents - State agency officials and advocates

(3) *Overreliance on traditional clinic or hospital services:* cited by respondents in 4 of 11 States and by two groups of respondents - State agency officials and local service providers.

Other areas cited were: cultural insensitivity and failure to believe that children and adolescents with serious emotional disturbance can be helped.

With respect to whether appropriate in-service curricula, training methods and training personnel are available, 48% of respondents **regionwide** said no, 20% left the answer blank, 20% said yes and 10% said there was availability in some areas. *The majority of respondents in 7 of 11 States either said curricula, methods or personnel was not available, or they did not know.* Three States said there was availability in some areas but not all. One State said curricula were available but not implemented. A majority of parents, state agency officials and local service providers also said curricula, methods or personnel were not available, or they did not know. Most advocates said curricula were available in some areas but not all.

Respondents **regionwide** attributed the unavailability of in-service training curricula, methods and personnel to, first of all, lack of funding to do training (checked by 53% of respondents), secondly, to lack of trainers (checked by 41%) and, thirdly, to lack of curricula (checked by 31%). Other reasons given were lack of vision regarding the need for training and staff time constraints to become involved in training.

Respondents were asked to rank, on a scale of 1-none to 10-extensive, the extent to which their respective States were conducting in-service training related to the delivery of community-based services for children and families. "2" was checked most often; the rankings of the majority of respondents **regionwide** (57%) fell in the range from 2 to 5.

By State, responses in the area of in-service training were as follows --

Alabama		
Need for In-Service Training:	8-10 range	
New Skills Needed:		Working with families Appropriate use of behavior management
Need to Change Inappropriate Skills/Attitudes:	7-10 range	
Inappropriate Skills/Attitudes Identified:		Attitudes toward families
Curricula/Methods/ Personnel Available:	100% No	
Reasons:		Lack of funding, lack of trainers
State Conducting In-Service training:		No consistent response
Comments:	"Curricula are not based on 'real life' but on text; therapeutic foster care training for foster parents is better than training for most social workers -- we need to move away from training as in 'how to do paper' to 'how to help kids'."	
Strategies:	State Mental Health Agency-University linkage to develop and implement child mental health training series for CMHC workers -- see: Roberts, M.C., Blount, R.L., Lyman, R.D. and Landolf-Fritsche, B. (1990). Collaboration of a University and State Mental Health Agency: Curriculum for Improving Services for Children. Professional Psychology: Research and Practice, 21, 69-71.	

Arkansas		
Need for In-Service Training:	8-10 range	
New Skills Needed:		• Understanding serious emotional disturbance • Working with families • Families need to learn skills, such as de-escalation
Need to Change Inappropriate Skills/Attitudes:	4-10 range	
Inappropriate Skills/Attitudes Identified:		Attitudes toward families Wedded to traditional outpatient model Cultural insensitivity Wedded to one specialty (i.e., not interdisciplinary)
Curricula/Methods/ Personnel Available:	57% Yes	**But** not implemented due to lack of priority, lack of funds and not enough trainers.
Reasons:		None listed
State Conducting In-Service training:		No consistent response; range from 1 (parent) to 10 (state agency official)
Comments:	"We are in the planning stage; there is hope but much to be done; few (local) centers can afford to send staff to central Arkansas for ... training."	
Strategies:	• University-State Mental Health Agency linkage, funded by the State, to develop case management training and parent training curricula and to do training • Development of interagency training package through CASSP • Greater Little Rock CMHC is conducting 4-session training with families and friends of the mentally ill to provide insight into how families feel, the effects of medications, how to obtain services, how to work with service providers, how to do estate planning	

Georgia		
Need for In-Service Training:	8-10 range	
New Skills Needed:		Working with families Cultural Competency Interagency collaboration New technologies, esp. in-home
Need to Change Inappropriate Skills/Attitudes:	9-10 majority	
Inappropriate Skills/Attitudes Identified:		Attitudes toward families Skepticism that children with serious emotional disturbance can be helped
Curricula/Methods/ Personnel Available:	71% No	
Reasons:		Lack of funding, lack of trainers, lack of curricula, lack of vision as to need, lack of time
State Conducting In-Service training:	1-3 range	
Comments:	"Training and travel dollars are frozen; there is no time to go to training when you have bulging caseloads; parents, as they become empowered, are training workers one at a time."	
Strategies:	Georgia Parent Support Network, Alliance for the Mentally Ill and Mental Health Association have sponsored relevant training.	

Kentucky		
Need for In-Service Training:	10	
New Skills Needed:		Interagency and interdisciplinary collaboration Flexibility and negotiation skills
Need to Change Inappropriate Skills/Attitudes:	9	
Inappropriate Skills/Attitudes Identified:		Resistance to interagency collaboration
Curricula/Methods/ Personnel Available:		Depends on area
Reasons:		None listed
State Conducting In-Service training:	6	
Strategies:	• Management training for interagency council staff • Service coordination training for interagency service planning • Parent/Professional training • Negotiation/problem-solving skills training (Developed by Kentucky IMPACT - Robert Wood Johnson Mental Health Services Program for Youth Kentucky Project)	

Louisiana		
Need for In-Service Training:	8-10	
New Skills Needed:		Working with families Appropriate use of behavior management
Need to Change Inappropriate Skills/Attitudes:	10	
Inappropriate Skills/Attitudes Identified:		Overreliance on hospital or out-of-home placement Attitudes toward families Skepticism that children with serious emotional disturbance can be helped
Curricula/Methods/ Personnel Available:	50% No	
Reasons:		Lack of curricula, funding and trainers
State Conducting In-Service training:	4-5 range	
Comments:	None	
Strategies:	Families as Allies Project	

<table>
<tr><th colspan="3">Mississippi</th></tr>
<tr><td>Need for In-Service Training:</td><td>7-10 range</td><td></td></tr>
<tr><td>New Skills Needed:</td><td></td><td>Working with families
Appropriate use of behavior management
Interdisciplinary & interagency collaboration
Crisis intervention skills</td></tr>
<tr><td>Need to Change Inappropriate Skills/Attitudes:</td><td>2-10 range</td><td></td></tr>
<tr><td>Inappropriate Skills/Attitudes Identified:</td><td></td><td>Resistance to interagency, interdisciplinary collaboration
Attitudes toward families</td></tr>
<tr><td>Curricula/Methods/ Personnel Available:</td><td>57% No</td><td></td></tr>
<tr><td>Reasons:</td><td></td><td>Lack of curricula, funding and personnel ("shortage of staff to create training materials and do training")</td></tr>
<tr><td>State Conducting In-Service training:</td><td></td><td>No consistent response</td></tr>
<tr><td>Comments:</td><td colspan="2">"Isolated (training) efforts by some mental health professionals, providers, but no linkage"; "a family education curriculum is available; case management and interagency collaboration is available; minority sensitivity and cultural differences will soon be implemented, but there is an extreme shortage of the necessary staff to continue review/revisions of these and creation of functioning materials, as well as those who can do training in the community"</td></tr>
<tr><td>Strategies:</td><td colspan="2">• Family Education Curriculum: Parent/Professional Teams developed and conduct training
• Case Management and Interagency Collaboration - Training of Trainers Model
• Cultural Relevance and Minority Sensitivity Training</td></tr>
</table>

North Carolina		
Need for In-Service Training:	8-9 range	
New Skills Needed:		• New community-based service technologies, esp. in-home services, treatment for sexual offenders, treatment for children in substance abusing families • Working with families • Interagency collaboration • Concept of system of care and "wraparound" services
Need to Change Inappropriate Skills/Attitudes:	8-10 range	
Inappropriate Skills/Attitudes Identified:		Overreliance on hospital, residential and traditional office-based psychotherapy Resistance to interagency coordination
Curricula/Methods/ Personnel Available:	67% No	
Reasons:		Lack of funding and trainers
State Conducting In-Service training:	3-5 range	
Comments:	None	
Strategies:	• State is developing a child mental health case management curriculum in conjunction with the University of North Carolina-Chapel Hill School of Social Work • Through the Fort Bragg Robert Wood Johnson Foundation project, a family empowerment curriculum is being developed (See: State Dept. of Mental Health, Child and Adolescent Division)	

Oklahoma		
Need for In-Service Training:	8-10 range	
New Skills Needed:		New community-based service technology Working with low income youth & families Working with minority youth & families Better clinic skills Professional ethics
Need to Change Inappropriate Skills/Attitudes:	5-10 range	
Inappropriate Skills/Attitudes Identified:		Attitudes toward families Cultural insensitivity Attitudes toward low income children and families Skepticism that children with serious emotional disturbance can be helped
Curricula/Methods/ Personnel Available:	67% No	
Reasons:		Lack of funding
State Conducting In-Service training:	7-8 range	
Comments:	None	
Strategies:	Through CASSP, monthly training sessions, parent/ professional seminars, development of standards	

South Carolina		
Need for In-Service Training:	8-10 range	
New Skills Needed:		New community-based service technologies, especially in-home and crisis intervention skills Cultural competency Working with the very young (birth to 3 years old)
Need to Change Inappropriate Skills/Attitudes:	3-7 range	
Inappropriate Skills/Attitudes Identified:		Attitudes toward sexual abuse and toward sexual offenders Inappropriate use of conduct disorder as diagnosis
Curricula/Methods/ Personnel Available:		71% of respondents left answer blank; 14% said no; 14% said in some areas
Reasons:		Lack of funding
State Conducting In-Service training:	2-5 range	
Comments:	None	
Strategies:	The S.C. Public-Academic Mental Health Consortium has potential to be effective mechanism for in-service training.	

Tennessee		
Need for In-Service Training:	8-10 range	
New Skills Needed:		Assessment and determination of appropriate level of care Case management skills
Need to Change Inappropriate Skills/Attitudes:	6	
Inappropriate Skills/Attitudes Identified:		Attitudes toward families
Curricula/Methods/ Personnel Available:	100% Blank	
Reasons:		None given
State Conducting In-Service training:	100% Blank	
Comments:	None	
Strategies:	None specified	

Texas		
Need for In-Service Training:	8-10 range	
New Skills Needed:		Interagency collaboration New community-based service technologies Assessment skills Use of computers
Need to Change Inappropriate Skills/Attitudes:	3-10 range	
Inappropriate Skills/Attitudes Identified:		Attitudes toward families Resistance to interagency collaboration Overreliance on hospital and traditional office-based services Appropriate use of behavior management Attitudes about sexual abuse "Lack of readiness to help clients address all problems" "Creative thinking about generating resources, especially in rural areas"
Curricula/Methods/ Personnel Available:		No consistent response: 29% said yes; 29% said in some areas; 29% said no; and, 29% left blank
Reasons:		Those who said "no" indicated lack of qualified trainers as the chief problem
State Conducting In-Service training:	2-5 range	
Comments:	None	
Strategies:	• NIMH HRD grant to develop interagency training package and provide cross-agency training in assessment and intervention skills, roles and responsibilities of agencies, family involvement, etc. • Curricula developed for training of community level interagency staffing teams • Case management training curricula are being developed	

Major groups of respondents provided the following responses in the area of in-service training:

Parents		
Need for In-Service Training:	10	
New Skills Needed:		Working with families Appropriate use of behavior management Case management skills Understanding emotional disturbance in children and adolescents
Need to Change Inappropriate Skills/Attitudes:	8-10 range	
Inappropriate Skills/Attitudes Identified:		Attitudes toward families ("closing parents off from the implementation of treatment plans - not part of the team; calling families 'dysfunctional'; 'we know what is best for you' attitudes; the view that families are at fault; the view that parents are troublemakers; the attitude that parents are too uneducated to help their child or know their child")
Curricula/Methods/ Personnel Available:		No consistent response: 43% said no; 29% said yes; and, 29% left blank
Reasons:		Lack of curricula, funding and trainers; also, lack of vision as to the need
State Conducting In-Service training:	1-7 range	
Comments:	None	
Strategies:	None specified	

State Agency Officials		
Need for In-Service Training:	7-10 range	
New Skills Needed:		Virtually all relate to CASSP system of care concepts, i.e., working with families, cultural competence, new community-based service technologies, interagency collaboration, individualized, flexible, "wraparound" services
Need to Change Inappropriate Skills/Attitudes:	2-10 range	
Inappropriate Skills/Attitudes Identified:		Attitudes toward families Cultural insensitivity Skepticism that children with serious emotional disorders can be helped Overreliance on hospital and out-of-home placements and on medical model of care
Curricula/Methods/ Personnel Available:	57% No	
Reasons:		Lack of funding and trainers
State Conducting In-Service training:	4-8 range	
Comments:	None	
Strategies:	None specified	

Local Service Providers

Need for In-Service Training:	8-10 range	
New Skills Needed:		Assessment skills Treatment for victims of sexual abuse Behavior management skills Use of computers Crisis intervention and case management skills In-home services Working with families (though this was cited far less often than by any other respondent group)
Need to Change Inappropriate Skills/Attitudes:	2-10 range	
Inappropriate Skills/Attitudes Identified:		Appropriate use of hospitalization Countertransference issues with abusive/ neglectful parents Distinguishing manipulative behavior from "driven" or "helpless" behavior Attitudes toward low income and minority youth and families Attitudes about sexual abuse
Curricula/Methods/ Personnel Available:	75% No	
Reasons:		Lack of curricula, funding and trainers
State Conducting In-Service training:	2-8 range	
Comments:	None	
Strategies:	None specified	

Advocates		
Need for In-Service Training:	8-10 range	
New Skills Needed:		Appropriate use of behavior management New community-based service technologies, especially in-home service techniques Interagency collaboration Working with families
Need to Change Inappropriate Skills/Attitudes:	3-8 range	No consistent response
Inappropriate Skills/Attitudes Identified:		Resistance to interdisciplinary collaboration Attitudes toward families Lack of knowledge about what services are available
Curricula/Methods/ Personnel Available:		No consistent response; depends on area
Reasons:		None specified
State Conducting In-Service training:	2-10 range	
Comments:	None	
Strategies:	None specified	

Section VI Results

Section VI relates to **recruitment** issues.

It was recognized that, given the lack of data, answers in this section would be "best guesses" and that some respondents might have difficulty even guessing. Parents had the most trouble -- 71% of parents left this section blank entirely.

Respondents were provided a checklist of possibilities to identify where States draw staff for the public child mental health system, and were asked to estimate the percentage of staff drawn from each. **Regionwide,** the top three responses were:

(1) *Higher education graduating students* - received the highest average "score" of 37%; was among the top three answers in all States except Oklahoma (and Tennessee, whose respondents left this section blank)

(2) *Adult mental health system* - received the second highest average score of 26%; was among the top three answers in every State except North Carolina, Kentucky and South Carolina

(3) *Other public child-serving systems, such as child welfare* - received the third highest average score of 24%; was among the top three answers in all States

Regionwide, respondents estimated that staff coming from higher education graduating students were drawn from the following levels --

(1) Most staff come from the *Bachelors and Masters levels* -- average scores virtually tied, with Bachelors level receiving an average score of 45.3% and Masters level an average score of 45.7%

(2) *Associates level* received the next highest average score of 11%

(3) *Doctoral level* received the third highest average score of 7%.

Respondents also most frequently checked that staff coming from higher education were drawn from *in-State, public 4-year colleges and universities.*

Respondents least frequently indicated that staff were drawn from the private for profit sector, higher education faculty or parents in staff roles. For example, only two respondents in total indicated that a small percentage of staff came from higher education faculty.

With respect to difficulties in recruiting different types of staff, there was a majority response only in the case of clinical staff. Otherwise, there was variation across States. **Regionwide**, the three types of staff most frequently cited as being the most difficult to recruit were --

(1) *Clinical staff* - cited by 57% of respondents; was among the top three answers in 9 States and among every major respondent group except parents

(2) *Case managers* - cited by 31% of respondents; was among the top three answers in 5 States and by State agency officials

(3) *Other direct care staff* - cited by 24% of respondents; was among the top three answers in 5 States and by parents and State agency officials.

Respondents indicated that their respective States had the *least* difficulty recruiting administrative support staff; this was the most frequently cited response in 7 of 11 States and by parents, State agency officials and local service providers.

With respect to difficulties in recruiting various disciplines, the only majority response was that of child psychiatrists. Otherwise, there was variation across States. **Regionwide,** the disciplines cited most frequently as being most difficult to recruit were --

(1) *Child psychiatrists* - cited by 73% of respondents; was among top three answers in every State except Kentucky and by every major respondent group except parents

(2) *Psychologists,* particularly at the Ph.D. level - cited by 27% of respondents; was among top three responses in 4 States and among local service providers

(3) *Psychiatrists* - cited by 20% of respondents; was among top three answers in 3 States and among all respondent groups except parents.

With respect to disciplines *least* difficult to recruit, there was little consistency **regionwide.** No discipline received a majority response. The two most frequently cited were --

(1) *Bachelor level social workers* - cited by 37% of respondents; among top three answers in 7 States and by parents and State agency officials

(2) *Mental health technicians* - cited by 24% of respondents; among top three answers in 4 States and by parents and local service providers

With respect to the type of service where States have the most difficulty recruiting, there was variation across the States and respondents had difficulty answering. The most frequently cited was *in-home services,* cited by 41% of respondents **regionwide**; this was the most frequently cited response in 8 States and by State agency officials, local service providers and advocates.

There also was variation as to the type of service where it was *least* difficult to recruit and, again, respondents had trouble answering. Most frequently cited (by 33% of respondents **regionwide**) was *clinic outpatient services;* this was the most frequently cited response in 7 States and by State agency officials and local service providers.

With respect to who does recruitment for the public child mental health system, most respondents identified a central personnel office in a State mental health agency. Respondents identified few strengths of State recruitment processes but described various weaknesses, most having to do with a lack of a specialized focus on children's services, bureaucratic obstacles and lack of funding.

Regionwide, few recruitment strategies were identified. Most were identified by local service providers and pertained more to efforts by individual local agencies than to any Statewide recruitment initiatives on behalf of children's services.

By State, responses in the area of recruitment were as follows --

Alabama		
Draws Staff from:	Adult mental health system Higher education graduating students Other child-serving systems	42% avg.* 19% avg. 16% avg.
Staff from Higher Education are:	Bachelors Masters Associates Doctoral	40%* 40% 13% 7%
Most Difficult Type of Staff to Recruit:	Case managers Clinical staff	75% 50%
Least Difficult Type of Staff to Recruit:	Administrative support staff	75%
Most Difficult Discipline to Recruit:	Child psychiatrists	50%
Least Difficult Discipline to Recruit:	No consistent response	
Most Difficult Type of Service to Recruit for:	Residential In-home Outpatient	75% 50% 50%
Least Difficult Type of Service to Recruit for:	Day treatment	75%
Most Staff from Higher Education are Drawn from:	4-year public colleges/universities in-State; next most from 2-year community colleges in-State	
Who Recruits:	One respondent checked central personnel office in State mental health agency. The others either left blank, said they did not know or had comments: "We don't have an organized recruitment for children's mental health services. We don't even have a director of child services in our state mental health agency."	
Recruitment Strategies:	None indicated.	

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*The percentages in this box represent the average estimates of the areas from which staff are drawn.

Arkansas		
Draws Staff from:	Other child-serving systems	39% avg.
	Higher education graduating students	35% avg.
	Adult mental health system	13% avg.
Staff from Higher Education are:	Bachelors	51%
	Masters	28%
	Associates	21%
	Doctoral	None
Most Difficult Type of Staff to Recruit:	Clinical staff	86%
	Case managers	86%
	Other direct care staff	57%
Least Difficult Type of Staff to Recruit:	Administrative support staff	43%
Most Difficult Discipline to Recruit:	Child psychiatrists	86%
	Parents in staff roles	43%
	Staff of color	43%
Least Difficult Discipline to Recruit:	No consistent response	
Most Difficult Type of Service to Recruit for:	In-home	86%
	Day treatment	43%
	Case management	43%
Least Difficult Type of Service to Recruit for:	Clinic outpatient	43%
	Residential	43%
Most Staff from Higher Education are Drawn from:	4-year in-State public colleges/universities; smaller numbers from historic Black colleges and community colleges in State or in region	
Who Recruits:	State agency respondents identified central personnel office in umbrella human services agency; parents and local providers say "no one" or "we do"	
Strengths of Recruitment Process:	Tries to identify well-qualified staff (though on the basis of credentials, not necessarily skills needed)	
Weaknesses of Recruitment:	Too generic; needs to specialize in child mental health	
Recruitment Strategies:	None specified (except putting ads in newspapers)	

Georgia		
Draws Staff from:	Higher education graduating students Other child-serving systems Adult mental health system	58% avg. 14% avg. 11% avg.
Staff from Higher Education are:	Masters Bachelors Associates Doctoral	47% 44% 8% 1%
Most Difficult Type of Staff to Recruit:	Clinical staff Other direct care staff	57% 43%
Least Difficult Type of Staff to Recruit:	Administrative support staff	43%
Most Difficult Discipline to Recruit:	Child psychiatrists Psychiatrists Psychologists	71% 57% 43%
Least Difficult Discipline to Recruit:	No consistent response (paraprofessionals cited by 29%)	
Most Difficult Type of Service to Recruit for:	In-home Residential	43% 43%
Least Difficult Type of Service to Recruit for:	Clinic outpatient	43%
Most Staff from Higher Education are Drawn from:	4-year public colleges/universities in State; next from 4-year colleges/ universities in region	
Who Recruits:	Central State personnel agency	
Strengths of Recruitment Process:	Central location brings in broader base of applicants	
Weaknesses of Recruitment:	Standardization of merit system ratings, which give higher ratings for such things as veteran status, may eliminate otherwise well qualified staff Cumbersome, time consuming, inefficient, slow Application rating and posting process is very lengthy	
Recruitment Strategies:	None specified	

Kentucky		
Draws Staff from:	Other child-serving systems Higher education graduating students Other States' mental health systems	100% avg. 100% avg. 100% avg.
Staff from Higher Education are:	Bachelors Masters	60% 40%
Most Difficult Type of Staff to Recruit:	Clinical staff Other direct care staff	100% 100%
Least Difficult Type of Staff to Recruit:	Administrative support staff	50%
Most Difficult Discipline to Recruit:	Social worker - MSW Parents in staff roles Paraprofessionals	100% 100% 100%
Least Difficult Discipline to Recruit:	Social worker - BA level	100%
Most Difficult Type of Service to Recruit for:	In-home Respite care School support services	100% 100% 100%
Least Difficult Type of Service to Recruit for:	Case manager	100%
Most Staff from Higher Education are Drawn from:	4-year public colleges/universities in State	
Who Recruits:	Central personnel office in umbrella human services agency	
Strengths of Recruitment Process:	None specified	
Weaknesses of Recruitment:	None specified	
Recruitment Strategies:	None specified	

Louisiana		
Draws Staff from:	Higher education graduating students	43% avg.
	Adult mental health system	34% avg.
	Other child-serving systems	10% avg.
Staff from Higher Education are:	Not specified	
Most Difficult Type of Staff to Recruit:	No consistent response	
Least Difficult Type of Staff to Recruit:	No consistent response	
Most Difficult Discipline to Recruit:	Child psychiatrists	100%
	Psychiatrists	100%
	Staff of color	100%
Least Difficult Discipline to Recruit:	No consistent response	
Most Difficult Type of Service to Recruit for:	In-home	50%
	Respite	50%
	Therapeutic foster care	50%
Least Difficult Type of Service to Recruit for:	Clinic outpatient	50%
	Residential	50%
	Case management	50%
Most Staff from Higher Education are Drawn from:	No consistent response	
Who Recruits:	Central personnel office in umbrella human services agency	
Strengths of Recruitment Process:	None specified	
Weaknesses of Recruitment:	Little specialized child and adolescent focus	
Recruitment Strategies:	None specified	

Mississippi		
Draws Staff from:	Higher education graduating students Adult mental health system Other child-serving systems	41% avg. 27% avg. 21% avg.
Staff from Higher Education are:	Bachelors Masters Doctoral Associates	55% 30% 8% 7%
Most Difficult Type of Staff to Recruit:	Clinical staff Other direct care staff	71% 43%
Least Difficult Type of Staff to Recruit:	No consistent response	
Most Difficult Discipline to Recruit:	Child psychiatrists Psychiatrists Psychologists	71% 57% 43%
Least Difficult Discipline to Recruit:	Social worker - B.A. level Mental health technician	71% 43%
Most Difficult Type of Service to Recruit for:	No consistent response	
Least Difficult Type of Service to Recruit for:	No consistent response	
Most Staff from Higher Education are Drawn from:	4-year public colleges/universities in State; next from private colleges/universities in State	
Who Recruits:	Local CMHCs	
Strengths of Recruitment Process:	Broad-based and individualized effort	
Weaknesses of Recruitment:	No coordinated planning or process	
Recruitment Strategies:	Media campaigns Comment: "There are a lot of advanced degree students in Mississippi, who could be given stipends to stay in the State."	

North Carolina		
Draws Staff from:	Other child-serving systems Higher education graduating students Other States' mental health systems	37% avg. 32% avg. 20% avg.
Staff from Higher Education are:	Masters Bachelors Associates Doctoral	52% 28% 13% 7%
Most Difficult Type of Staff to Recruit:	Clinical staff Program supervisors Mid-level managers	100% 67% 67%
Least Difficult Type of Staff to Recruit:	Administrative support staff	33%
Most Difficult Discipline to Recruit:	Child psychiatrists Psychologists	100% 67%
Least Difficult Discipline to Recruit:	Social worker - B.A. level Mental health technician	100% 67%
Most Difficult Type of Service to Recruit for:	In-home Day treatment	100% 100%
Least Difficult Type of Service to Recruit for:	Group home staff Other direct care staff Clinic outpatient	100% 100% 67%
Most Staff from Higher Education are Drawn from:	4-year public colleges and universities in State	
Who Recruits:	Central personnel office in State mental health agency at State level; children's programs at local level	
Strengths of Recruitment Process:	Generally responsive to requests for position reviews, special "rush" orders, etc.	
Weaknesses of Recruitment:	No coordinated recruitment or retention process Poor understanding of local programs' needs Inconsistent application of criteria for qualifying applicants for various personnel series	
Recruitment Strategies:	Professional word-of-mouth, telephone networks often still work best. Approaching specialty training areas about specific areas of need (such as infant mental health) also helps, using detailed "flyers", personal contacts, etc. "When we use newspapers, we are detailed in our descriptions of the position. Direct child care staff are always involved in interviews." Also, use of internships.	

Oklahoma

Draws Staff from:	Adult mental health system Private non-profit sector Other child-serving systems Higher education graduating students (came in fourth)	32% avg. 32% avg. 17% avg. 15% avg.
Staff from Higher Education are:	Bachelors Masters Associates Doctoral	55% 35% 7% 3%
Most Difficult Type of Staff to Recruit:	Program supervisors Senior managers	67% 67%
Least Difficult Type of Staff to Recruit:	No consistent response	
Most Difficult Discipline to Recruit:	Child psychiatrists Staff of color	100% 67%
Least Difficult Discipline to Recruit:	No consistent response	
Most Difficult Type of Service to Recruit for:	In-home Case management	67% 67%
Least Difficult Type of Service to Recruit for:	Clinic outpatient Day treatment	100% 67%
Most Staff from Higher Education are Drawn from:	4-year public colleges/universities in State; next from private colleges and universities in State	
Who Recruits:	Central personnel office in State mental health agency	
Strengths of Recruitment Process:	State pay scales are competitive (especially compared to private, non-profit) Dedicated staff	
Weaknesses of Recruitment:	State system is entrenched, disorganized, lacks funds, too much paperwork	
Recruitment Strategies:	None specified	

South Carolina		
Draws Staff from:	Higher education graduating students Other States' mental health systems Other child-serving systems	50% avg. 50% avg. 15% avg.
Staff from Higher Education are:	Masters Doctoral	87% 13%[*]
Most Difficult Type of Staff to Recruit:	Clinical staff (only response)	40%
Least Difficult Type of Staff to Recruit:	No response	
Most Difficult Discipline to Recruit:	Child psychiatrists Psychologists Psychiatric nurses	80% 60% 60%
Least Difficult Discipline to Recruit:	Social workers - MSW Mental health technicians	60% 40%
Most Difficult Type of Service to Recruit for:	In-home (only response)	40%
Least Difficult Type of Service to Recruit for:	No consistent response	
Most Staff from Higher Education are Drawn from:	4-year public colleges/universities in State	
Who Recruits:	Central personnel office in State mental health agency; also local CMHCs	
Strengths of Recruitment Process:	None specified	
Weaknesses of Recruitment:	No focus on children and adolescents Lacks resources	
Recruitment Strategies:	None specified	

Tennessee
No responses given.

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[*] This was a consistent response from both State agency and local provider respondents.

Texas		
Draws Staff from:	Higher education graduating students	28% avg.
	Adult mental health system	22% avg.
	Other child-serving systems	20% avg.
Staff from Higher Education are:	Masters	53%
	Bachelors	30%
	Doctoral	12%
	Associates	5%
Most Difficult Type of Staff to Recruit:	Clinical staff	43%
	Case managers	29%
Least Difficult Type of Staff to Recruit:	Administrative support staff	29%
Most Difficult Discipline to Recruit:	Child psychiatrists	72%
	Psychiatrists	57%
	Special educators	43%
Least Difficult Discipline to Recruit:	Social workers	57%
	Mental health technicians	57%
Most Difficult Type of Service to Recruit for:	No consistent response (71% of respondents did not answer)	
Least Difficult Type of Service to Recruit for:	Clinic outpatient services (only response given)	29%
Most Staff from Higher Education are Drawn from:	4-year public colleges/universities in State	
Who Recruits:	Central personnel office in State mental health agency and local providers	
Strengths of Recruitment Process:	None specified	
Weaknesses of Recruitment:	Central office is bureaucratic, traditional and lacks innovation Lack of sufficient attention to employ a diversified group of staff on the Masters level and to attract doctoral level staff in some localities	
Recruitment Strategies:	None specified	

Major groups of respondents gave the following responses with respect to recruitment --

Parents Parents left blank many of the questions in this section. Responses were provided to the following:		
Most Difficult Type of Staff to Recruit:	Direct care staff	43%
Least Difficult Type of Staff to Recruit:	Administrative support staff	29%
Most Difficult Discipline to Recruit:	Special educators	43%
Least Difficult Discipline to Recruit:	Social worker - B.A. level Mental health technician	29% 29%
Comments:	Parents could not identify who does recruitment, nor did they specify strategies. There were several comments to the effect that questions about recruitment processes did not apply because "we do not have a child mental health system in our State."	

State Agency Officials State agency officials identified the following areas of difficulty in recruitment:		
Most Difficult Type of Staff to Recruit:	Clinical staff Case managers Other direct care staff	71% 50% 36%
Least Difficult Type of Staff to Recruit:	Administrative support staff	36%
Most Difficult Discipline to Recruit:	Child psychiatrists Psychiatrists	93% 50%
Least Difficult Discipline to Recruit:	Social worker - B.A. level especially	71%
Most Difficult Type of Service to Recruit for:	In-home	50%
Least Difficult Type of Service to Recruit for:	Clinic outpatient	43%
Comments:	While State agency officials identified who does recruitment in their respective States, they cited few recruitment strategies. (Most strategies were identified by local providers.)	

Local Service Providers

Local providers identified the following areas of difficulty in recruitment:

Most Difficult Type of Staff to Recruit:	Clinical staff	75%
Least Difficult Type of Staff to Recruit:	Administrative support staff and direct care staff	both 31%
Most Difficult Discipline to Recruit:	Child psychiatrists Psychologists, especially Ph.Ds. Psychiatrists	75% 50% 44%
Least Difficult Discipline to Recruit:	Mental Health technicians and paraprofessionals	31%
Most Difficult Type of Service to Recruit for:	In-home	56%
Least Difficult Type of Service to Recruit for:	Clinic outpatient	56%
Comments:	None	

Advocates

Advocates, after parents, had the most difficulty answering this section. They provided the following responses:

Most Difficult Type of Staff to Recruit:	Clinical staff	60%
Least Difficult Type of Staff to Recruit:	No consistent response	
Most Difficult Discipline to Recruit:	Child psychiatrists Special educators (trained in mental health) Psychiatrists Psychiatric nurses	80% 60% 40% 40%
Least Difficult Discipline to Recruit:	Mental health technician/ paraprofessionals	40%
Most Difficult Type of Service to Recruit for:	In-home Crisis services	40% 40%
Least Difficult Type of Service to Recruit for:	No consistent response; 80% left blank	
Comments:	Like parents, advocates did not identify any recruitment strategies.	

Section VII Results

Section VII relates to **retention** issues.

Respondents had even greater difficulty answering questions related to retention than they did with recruitment issues. In addition, there was even less consistency in responses. Again, parents and advocates had the most difficulty answering retention questions. However, State mental health agency officials also had difficulty; local service providers, relatively speaking, had the least trouble.

Respondents were asked to rank, on a scale of 1-low to 10-high, the extent to which retention was a problem in their respective States. **Regionwide,** there was little consistency in the rankings, which ranged from a low of 2 to a high of 10. (Some of those who gave this a low ranking, indicating that retention was not a major issue, explained that this was because the children's system was just beginning to develop so recruitment was more of an issue than retention.)

Respondents were asked to check and then rank the top three reasons staff leave the public child mental health system. Various reasons were checked and none received a top three ranking by a majority of respondents, reflecting different views across States and by type of respondent. The top three reasons cited were:

(1) *Better salaries* - ranked in top three by 49% of respondents; was among the top three reasons in 8 States and among all four major respondent groups

(2) *More manageable caseloads* - ranked by 33% of respondents; among top three answers in 4 States and among parents and advocates

(3) *Frustration with bureaucracy* - ranked by 24% of respondents; among top three answers in 4 States and among local service providers and advocates.

tied with

(4) *Feel ineffective with clients because of lack of access to resources* - ranked by 24% of respondents; among top three answers in 4 States and among State agency officials, parents and local providers.

Regionwide, respondents prioritized the top three places staff go when they leave as --

(1) *Private practice and the private for profit sector* (i.e. a for profit hospital) - tied as the number one answer; each cited by 53% of respondents; was among top three answers in 9 off 11 States and by all major respondent groups except parents

(2) *Private non profit sector* - cited by 37% of respondents; among top three answers in 6 States and among State agency officials and advocates

(3) *Other public child-serving systems* - cited by 20% of respondents; among top three answers in 5 States and among local service providers.

Regionwide, respondents indicated that the top three most difficult types of staff to retain are the following:

(1) *Clinical staff* - cited by 61% of respondents; among top three answers in all States (except Tennessee, which left this entire section blank) and among all four major respondent groups

(2) *Case managers* - cited by 45% of respondents; among top three answers in 7 States and among all four respondent groups

(3) *Other direct care staff* - cited by 31% of respondents; among top three answers in 4 States and among all four respondent groups.

Respondents indicated that the least difficult type of staff to retain are *administrative support staff* and *senior managers* - among top three answers in 9 States and among State agency officials , local service providers and parents.

With respect to the most difficult discipline to retain, the only majority response was that of *child psychiatrists,* which was cited by 53% of respondents **regionwide** and was among the top three answers in 8 States and among the four major respondent groups. The next closest were: psychologists, especially at the Ph.D. level, cited by 29% of respondents, among top three answers in 5 States and among local providers; social workers and psychiatrists, each cited by 20% of respondents.

There was no consistency **regionwide** as to which disciplines were the least difficult to retain.

With respect to which type of service was the most difficult in which to retain staff, again, there was little consistency **regionwide.** *In-home services* was the most frequently cited response in 8 States and by State agency officials and local providers. There was also little consistency regarding the type of service in which it is least difficult to retain staff. *Clinic outpatient services* was most frequently cited by 5 States and by State agency officials and local providers.

There were few retention strategies described **regionwide.** Local service providers were the group that most typically identified strategies and, as with recruitment strategies, they tended to pertain to efforts by individual local agencies, rather than statewide initiatives.

By State, respondents provided the following responses related to retention --

Alabama		
Retention as a Problem:		7-10 range
Top 3 Reasons Staff Leave:	Better salaries Opportunities for advancement Feel ineffective with clients because of lack of access to resources	50% 50% 50%
Where Staff Go:	Private practice Private for-profit sector Return to school	50% 50% 50%
Most Difficult Type of Staff to Retain:	Clinical staff Case managers Other direct care staff	75% 75% 50%
Least Difficult Type of Staff to Retain:	Administrative support staff	50%
Most Difficult Discipline to Retain:	Child psychiatrists (only consistent response)	50%
Least Difficult Discipline to Retain:	No consistent response (one respondent said, "Parents in staff roles - there aren't any."	
Most Difficult Type of Service in which to Retain Staff:	Case management In-home Residential Outpatient	75% 50% 50% 50%
Least Difficult Type of Component in which to Retain Staff:	Day treatment	50%
Retention Strategies:	None specified	

Arkansas		
Retention as a Problem:		7-9 range
Top 3 Reasons Staff Leave:	Frustration with bureaucracy	71%
	More manageable caseloads	57%
	Feel ineffective with clients because of lack of access to resources	57%
Where Staff Go:	Private practice	71%
	Private for-profit sector	71%
	Private non-profit sector	57%
Most Difficult Type of Staff to Retain:	Other direct care staff	86%
	Case managers	86%
	Clinical staff	71%
Least Difficult Type of Staff to Retain:	Administrative support staff	43%
Most Difficult Discipline to Retain:	Child psychiatrists	71%
	Social workers - MSW	57%
	Psychologists	43%
Least Difficult Discipline to Retain:	No consistent response	
Most Difficult Type of Service in which to Retain Staff:	Case management	43%
Least Difficult Type of Component in which to Retain Staff:	Residential	43%
Retention Strategies:	CMHC has flexible schedules and excellent fringe benefits Supportive management and staff structure, including: decisions made at lowest effective levels; supervision by networking; supervisor available to problem-solve as needed; staff can manage their own workloads	

Georgia		
Retention as a Problem:		4-10 range
Top 3 Reasons Staff Leave:	More manageable caseloads Better salaries Better hours and working conditions	57% 43% 43%
Where Staff Go:	Out of field altogether Private practice Private for-profit sector Private non-profit sector	57% 43% 43% 43%
Most Difficult Type of Staff to Retain:	Clinical staff Case managers	57% 43%
Least Difficult Type of Staff to Retain:	Administrative support staff	43%
Most Difficult Discipline to Retain:	Child psychiatrists (only consistent response)	43%
Least Difficult Discipline to Retain:	No consistent response	
Most Difficult Type of Service in which to Retain Staff:	No consistent response	
Least Difficult Type of Component in which to Retain Staff:	No consistent response	
Retention Strategies:	Excellent benefits Increased clinical supervision and support Adjusted leave time	

Kentucky		
Retention as a Problem:		No ranking
Top 3 Reasons Staff Leave:	Better salaries	100%
Where Staff Go:	Other public child-serving systems	100%
Most Difficult Type of Staff to Retain:	Case managers	100%
Least Difficult Type of Staff to Retain:	Senior managers	100%
Most Difficult Discipline to Retain:	Mental health technicians MSW social workers Paraprofessionals	100% 100% 100%
Least Difficult Discipline to Retain:	Psychiatrists Psychologists	100% 100%
Most Difficult Type of Service in which to Retain Staff:	In-home Respite	100% 100%
Least Difficult Type of Component in which to Retain Staff:	Administration	100%
Retention Strategies:	Increased training to revitalize staff	

Louisiana		
Retention as a Problem:		8
Top 3 Reasons Staff Leave:	Better salaries	100%
	Betters hours and working conditions	100%
	Frustration with bureaucracy	100%
	Too much paperwork	100%
	Feel ineffective with clients because of lack of access to resources	100%
Where Staff Go:	Private practice	100%
	Private for-profit sector	100%
	Private non-profit sector	50%
	Other public child-serving systems	50%
	Out of field	50%
	Return to school	50%
Most Difficult Type of Staff to Retain:	Clinical staff	100%
	Mid-level managers	100%
Least Difficult Type of Staff to Retain:	Senior managers	50%
Most Difficult Discipline to Retain:	Child psychiatrists	50%
	Psychiatrists	50%
	Psychologists	50%
	Psychiatric nurses	50%
Least Difficult Discipline to Retain:	Social workers	100%
Most Difficult Type of Service in which to Retain Staff:	In-home	50%
	Respite	50%
	Therapeutic foster care	50%
Least Difficult Type of Component in which to Retain Staff:	Residential	50%
	School-based	50%
	Clinic outpatient	50%
Retention Strategies:	None specified	

Mississippi		
Retention as a Problem (Comment: "Retention is not yet an issue because child and adolescent system is so new!"):		3-8 range
Top 3 Reasons Staff Leave:	Better salaries More manageable caseloads (only consistent responses)	100% 71%
Where Staff Go:	Private non-profit sector Private practice Private for-profit sector Other public child-serving systems	71% 57% 57% 43%
Most Difficult Type of Staff to Retain:	Clinical staff Case managers	71% 43%
Least Difficult Type of Staff to Retain:	No consistent response	
Most Difficult Discipline to Retain:	Child psychiatrists Psychiatrists	71% 57%
Least Difficult Discipline to Retain:	Social workers Mental health technicians	43% 43%
Most Difficult Type of Service in which to Retain Staff:	In-home Outpatient	43% 43%
Least Difficult Type of Component in which to Retain Staff:	No consistent response	
Retention Strategies:	At local program level, flexible hours, good benefits, leave time or stipend to attend state and national conferences, tuition credit, team building	

North Carolina		
Retention as a Problem:		5-10 range
Top 3 Reasons Staff Leave:	Better salaries Feel ineffective with clients because of lack of access to resources More manageable caseloads	100% 67% 67%
Where Staff Go:	Private for-profit sector Private practice Private non-profit sector	100% 67% 67%
Most Difficult Type of Staff to Retain:	Clinical staff Case managers Other direct care staff	100% 100% 67%
Least Difficult Type of Staff to Retain:	Senior managers	100%
Most Difficult Discipline to Retain:	Psychologists, esp. at Ph.D. level MSW social workers	100% 67%
Least Difficult Discipline to Retain:	No consistent response	
Most Difficult Type of Service in which to Retain Staff:	Case management In-home Outpatient	100% 67% 67%
Least Difficult Type of Component in which to Retain Staff:	No consistent response (Comment: "It is difficult to retain staff at all levels.")	
Retention Strategies:	At local program level, good salaries and benefits, developing treatment models that work (encouraging innovation and flexibility), giving individuals both the authority and responsibility to get the job done, providing ongoing training, development of an organization structure that supports staff.	
Recommended Strategies:	• Expand/create financially supported internships in problem areas, such as case management and in-home; • Increase relative pay scales for "high burnout" positions, such as family preservation, emergency services (should be done without requiring higher entry level skills or higher personnel qualification categories); • Increase percentage of paid staff time dedicated to consultation and education activities specific to job category, in-house on-the-job training activities and team support/peer supervision activities; • Promote special recognition for successful interventions, special programs; • Encourage provider staff to also teach (locally, through internships and by outside workshops); • Promote opportunities for in-house promotion.	

Oklahoma		
Retention as a Problem:		3-10 range
Top 3 Reasons Staff Leave:	Too much paperwork	100%
	Better salaries	67%
	Lack of status	67%
Where Staff Go:	Private for-profit sector	100%
	Private practice	67%
	Other public child-serving systems	67%
	Return to school	67%
Most Difficult Type of Staff to Retain:	Clinical staff	100%
	Mid-level managers	67%
	Program supervisors	67%
Least Difficult Type of Staff to Retain:	No consistent response	
Most Difficult Discipline to Retain:	Child psychiatrists	100%
	Psychiatrists	67%
	Psychologists	67%
Least Difficult Discipline to Retain:	Mental health technicians	67%
	Paraprofessionals	67%
Most Difficult Type of Service in which to Retain Staff:	Case management	67%
	In-home	67%
	Day treatment	67%
	Residential	67%
Least Difficult Type of Component in which to Retain Staff:	Clinic outpatient	100%
Retention Strategies:	Bi-yearly retreats Four times a year regional meetings State sponsored awards ceremonies	

South Carolina		
Retention as a Problem:		4-8 range
Top 3 Reasons Staff Leave:	Better salaries Opportunities for advancement Frustration with bureaucracy	60% 60% 40%
Where Staff Go:	Private practice Private for-profit sector	60% 40%
Most Difficult Type of Staff to Retain:	Clinical staff Mid-level managers Program supervisors	40% 40% 40%
Least Difficult Type of Staff to Retain:	No consistent response	
Most Difficult Discipline to Retain:	Psychologists Child psychiatrists Psychiatrists Psychiatric nurses	60% 40% 40% 40%
Least Difficult Discipline to Retain:	No consistent response	
Most Difficult Type of Service in which to Retain Staff:	In-home	40%
Least Difficult Type of Component in which to Retain Staff:	No consistent response (80% left blank)	
Retention Strategies:	None specified	

Tennessee
No responses given.

Texas		
Retention as a Problem:		6-8 range
Top 3 Reasons Staff Leave:	Frustration with bureaucracy Lack of status Betters hours and working conditions Too much paperwork Conflict with administration's policies	43% 43% 29% 29% 29%
Where Staff Go:	Other public child-serving systems Private practice Private for-profit sector Private non-profit sector	43% 29% 29% 29%
Most Difficult Type of Staff to Retain:	Clinical staff Case managers Senior managers	29% 29% 29%
Least Difficult Type of Staff to Retain:	No consistent response	
Most Difficult Discipline to Retain:	Child psychiatrists Staff of color	43% 29%
Least Difficult Discipline to Retain:	Social workers Mental health technicians	29% 29%
Most Difficult Type of Service in which to Retain Staff:	No response given	
Least Difficult Type of Component in which to Retain Staff:	No response given	
Retention Strategies:	At local level, in-house professional development seminars, compensated leave for attendance at professional conferences	
Recommended Strategies:	Bonus pay for outstanding accomplishment, yearly salary increases for good performance, dues payment for membership in professional societies, compensation for renewal of certification/licensure, flexible hours, conversion of sick time to vacation time	

Major respondent groups provided the following responses related to retention --

Parents		
Retention as a Problem:		10
Top 3 Reasons Staff Leave:	Feel ineffective with clients because of lack of access to resources More manageable caseloads	43% 43%
Where Staff Go:	Out of field altogether Return to school	29% 29%
Most Difficult Type of Staff to Retain:	Case managers Clinical staff Other direct care staff	43% 43% 29%
Least Difficult Type of Staff to Retain:	Senior managers	29%
Most Difficult Discipline to Retain:	Mental health technicians Child psychiatrists MSWs	43% 29% 29%
Least Difficult Discipline to Retain:	Parents in staff roles ("there aren't any!")	29%
Most Difficult Type of Service in which to Retain Staff:	No consistent response	
Least Difficult Type of Component in which to Retain Staff:	No consistent response	
Retention Strategies:	Parents did not identify any strategies	

State Agency Officials		
Retention as a Problem:		3-10 range
Top 3 Reasons Staff Leave:	Better salaries	93%
	Opportunities for advancement	36%
	Feel ineffective with clients because of lack of access to resources	50%
Where Staff Go:	Private for-profit sector	71%
	Private practice	57%
	Private non-profit sector	57%
Most Difficult Type of Staff to Retain:	Clinical staff	64%
	Case managers	57%
	Program supervisors	36%
	Other direct care staff	36%
Least Difficult Type of Staff to Retain:	Senior managers and administrative support staff	57%
Most Difficult Discipline to Retain:	Child psychiatrists	64%
	Psychologists	50%
	MSWs	50%
Least Difficult Discipline to Retain:	Mental health technicians	57%
	Paraprofessionals	57%
Most Difficult Type of Service in which to Retain Staff:	In-home	57%
	Case management	43%
Least Difficult Type of Component in which to Retain Staff:	Clinic outpatient	43%
Retention Strategies:	Very few specified	

Local Service Providers		
Retention as a Problem (no consistent ranking):		3-10 range
Top 3 Reasons Staff Leave:	Better salaries	81%
	Frustration with bureaucracy	38%
	Feel ineffective with clients because of lack of access to resources	56%
Where Staff Go:	Private practice	75%
	Private for-profit sector	56%
	Other public child-serving systems	50%
Most Difficult Type of Staff to Retain:	Clinical staff	88%
	Case managers	50%
	Other direct care staff	38%
	Program administrators	38%
Least Difficult Type of Staff to Retain:	Senior managers and administrative support staff	50%
Most Difficult Discipline to Retain:	Child psychiatrists	56%
	Psychiatrists	56%
	Psychologists, especially Ph.D.	56%
Least Difficult Discipline to Retain:	Mental health technicians	50%
	Social workers, especially B.A. level	50%
Most Difficult Type of Service in which to Retain Staff:	In-home	43%
	Residential	38%
	Clinic outpatient	38%
Least Difficult Type of Component in which to Retain Staff:	Clinic outpatient	38%
Retention Strategies:	A few specified	

Advocates		
Retention as a Problem:		6
Top 3 Reasons Staff Leave:	Frustration with bureaucracy	40%
Where Staff Go:	Private practice Private for-profit sector Private non-profit sector	40% 40% 40%
Most Difficult Type of Staff to Retain:	No response	
Least Difficult Type of Staff to Retain:	No response	
Most Difficult Discipline to Retain:	Child psychiatrists	40%
Least Difficult Discipline to Retain:	No consistent response	
Most Difficult Type of Service in which to Retain Staff:	No consistent response	
Least Difficult Type of Component in which to Retain Staff:	No consistent response	
Retention Strategies:	Advocates did not identify any strategies	

Section VIII Results

Section VIII relates to **staff distribution and utilization** issues.

Respondents had difficulty answering the questions in this section that related to recruitment and retention as they affect distribution. Parents and advocates had the most difficulty, local service providers, relatively speaking, the least.

Respondents were asked to check and then rank the top three types of service where States have the most difficulty recruiting and retaining staff. No one type of service received a top three ranking by a majority of respondents, reflecting differences across States and by type of respondent. **Regionwide,** the three most consistently ranked were --

(1) *Crisis services* (ranked in the top three by 33% of respondents; among top three answers in 8 States and all major respondent groups, except parents)

(2) *In-home services* (ranked by 29% of respondents; among top three answers in 6 States and by State agency officials and local providers)

(3) *Therapeutic foster care* (cited by 20% of respondents; among top three answers in 4 States and by all major respondent groups, except parents).

Respondents attributed difficulties in recruiting and retaining staff in these components to: (listed in order of frequency cited)--

(1) high levels of stress
(2) low pay
(3) irregular schedule
(4) lack of supports
(5) long hours
(6) inadequate training
(7) high caseloads
(8) fear for safety.

Regionwide, respondents identified the type of service where States have the least difficulty recruiting and retaining staff as --

(1) *Clinic outpatient* (cited by 16% of respondents; among top three answers in 8 States and by all major respondent groups, except parents)

Note: There was little consistency beyond this answer; many respondents, including all parents, did not answer this question.

Respondents identified the main reasons why States have the least difficulty recruiting and retaining staff in clinic outpatient services as (listed in order of frequency cited):

(1) regular hours (i.e. 9 to 5 job)
(2) regular schedule (i.e. no on-call, crisis hours)
(3) have back-up supports
(4) not as stressful
(5) is most like private practice.

Regionwide, respondents identified the service locations where States have the most difficulty recruiting and retaining staff as --

(1) *Services in a juvenile corrections setting* (cited by 41% of respondents; among top three answers in 8 States and by all major respondent groups, except parents)

(2) *Services in a child welfare system setting* (for example, in child protective services) - (cited by 33% of respondents; among top three answers in 8 States and by State agency officials and local providers.

Regionwide, respondents identified the service locations where States have the least difficulty recruiting and retaining staff as--

(1) *Mental health clinic based* (cited by 45%; among top three answers in 9 States and by all major respondent groups., except parents)

(2) *School based services* (cited by 24%; among top three answers in 5 States and by local providers)

(3) *Hospital based* (cited by 24%; among top three answers in 4 States and by State agency officials and advocates).

Regionwide, *61% of respondents identified rural areas as the most geographically understaffed areas of their respective States.* This was the top answer in all States (except Tennessee, which provided no answers in this section). 12% of respondents also identified small towns and communities (respondents in 3 States), and 8% identified inner cities (respondents in 3 States).

Regionwide, there were few strategies cited with respect to distribution and utilization issues.

By State, respondents provided the following responses in this area:

Alabama		
Most difficult type of service in which to recruit and retain staff:	Case management In-home services Residential treatment	75% 50% 50%
Why difficult:	High stress levels; lack of supports; inadequate training	
Least difficult type of service in which to recruit and retain staff:	Clinic outpatient	50%
Why not as difficult:	Not as much stress	
Most difficult service location in which to recruit and retain staff:	Services in a juvenile corrections setting Services in a child welfare system setting Residential setting	75% 50% 50%
Least difficult service location in which to recruit and retain staff:	Hospital based Services in a primary health care setting	50% 50%
Most geographically understaffed area of State:	Rural	
Strategies:	None specified	

Arkansas		
Most difficult type of service in which to recruit and retain staff:	Case management Therapeutic foster care Crisis services In-home services	71% 57% 57% 57%
Why difficult:	Inadequate training; low pay; fear for safety	
Least difficult type of service in which to recruit and retain staff:	No consistent response; inpatient and day treatment mentioned	
Why not as difficult:	No consistent response	
Most difficult service location in which to recruit and retain staff:	Services in a juvenile corrections setting Services in a child welfare system setting	57% 57%
Least difficult service location in which to recruit and retain staff:	No consistent response; inpatient, clinic outpatient, residential and school-based all mentioned	
Most geographically understaffed area of State:	Rural, especially the Delta area; also small towns; one respondent said, "Entire State!"	
Strategies:		

Georgia		
Most difficult type of service in which to recruit and retain staff:	Crisis services Residential	29% 29%
Why difficult:	Lack of supports; long hours; fear for safety; irregular schedule	
Least difficult type of service in which to recruit and retain staff:	Clinic outpatient Administration	29% 29%
Why not as difficult:	9 to 5 positions and office based	
Most difficult service location in which to recruit and retain staff:	Services in a juvenile corrections setting Services in a child welfare system setting Residential setting	29% 29% 29%
Least difficult service location in which to recruit and retain staff:	No consistent response; clinic outpatient, school-based and services in a primary health care setting all mentioned	
Most geographically understaffed area of State:	Rural; also small communities and inner city	
Strategies:	Occasionally, salary supplements	

Kentucky		
Most difficult type of service in which to recruit and retain staff:	Crisis services	100%
	Respite services	100%
	In-home services	100%
Why difficult:	Irregular schedules	
Least difficult type of service in which to recruit and retain staff:	Administration	50%
Why not as difficult:	Stable schedules	
Most difficult service location in which to recruit and retain staff:	Services in a child welfare system setting	100%
	Any "off-site" services	100%
Least difficult service location in which to recruit and retain staff:	Mental health clinic based	
Most geographically understaffed area of State:	Rural	
Strategies:	Pilot projects in partnership with university to cover tuition in return for "payback service" in underserved areas	

Louisiana		
Most difficult type of service in which to recruit and retain staff:	Crisis services Therapeutic foster care Respite services Note: One respondent noted that, because the State does not have a history of recruiting for all services, it is difficult to make comparisons.	50% 50% 50%
Why difficult:	Lack of supports; "system still geared to supporting hospital and residential levels of care."	
Least difficult type of service in which to recruit and retain staff:	Clinic outpatient, inpatient and administration	all cited by 50%
Why not as difficult:	Regular hours, comfortable setting	
Most difficult service location in which to recruit and retain staff:	Services in a juvenile corrections setting Services in a child welfare system setting	50% 50%
Least difficult service location in which to recruit and retain staff:	Mental health clinic based Hospital based School based	100% 50% 50%
Most geographically understaffed area of State:	Rural; also, inner city, especially with respect to retention of direct care staff	
Strategies:	None specified	

Mississippi		
Most difficult type of service in which to recruit and retain staff:	Clinic outpatient Inpatient Crisis services Residential	57% 43% 29% 29%
Why difficult:	Low pay; heavy caseloads; high stress; long hours	
Least difficult type of service in which to recruit and retain staff:	Administration Clinic outpatient	43% 29%
Why not as difficult:	Provide steppingstone to private practice; more qualified applicants	
Most difficult service location in which to recruit and retain staff:	Services in a child welfare system setting Mental health clinic based (also see below)	43% 43%
Least difficult service location in which to recruit and retain staff:	Mental health clinic based	29%
Most geographically understaffed area of State:	Rural, especially Delta area	
Strategies:	None specified	

North Carolina		
Most difficult type of service in which to recruit and retain staff:	In-home services Therapeutic foster care	100% 100%
Why difficult:	Irregular hours; low pay; high stress	
Least difficult type of service in which to recruit and retain staff:	Clinic outpatient Group homes	100% 67%
Why not as difficult:	Traditional mental health roles	
Most difficult service location in which to recruit and retain staff:	Services in a juvenile corrections setting Services in a child welfare system setting	67% 67%
Least difficult service location in which to recruit and retain staff:	Mental health clinic based	67%
Most geographically understaffed area of State:	Rural, especially eastern part of the State; also inner city	
Strategies:	Use of "trial run" contracts to encourage professionals to provide contract services to underserved areas. Although per hour contract costs for Ph.D., M.D. and MSW are often higher than rural, poorer areas of the State can afford, "trial run" contracts "serve to expose professionals to program areas and positive staff support systems that they would otherwise be ignorant of; in a few cases, these consultants have ended up committing more time to these understaffed areas as a result of this exposure".	

Oklahoma		
Most difficult type of service in which to recruit and retain staff:	In-home services Crisis services	67% 67%
Why difficult:	Low pay; inadequate training	
Least difficult type of service in which to recruit and retain staff:	Clinic outpatient	100%
Why not as difficult:	Traditional model; office based	
Most difficult service location in which to recruit and retain staff:	Services in a juvenile corrections setting Residential setting	100% 100%
Least difficult service location in which to recruit and retain staff:	Mental health clinic based School-based	100% 67%
Most geographically understaffed area of State:	Rural	
Strategies:	None specified	

South Carolina		
Most difficult type of service in which to recruit and retain staff:	No consistent response; in-home services, case management, inpatient mentioned	
Why difficult:	Long hours; high stress	
Least difficult type of service in which to recruit and retain staff:	Clinic outpatient and administration	20% each
Why not as difficult:	Regular hours; no crisis on-call	
Most difficult service location in which to recruit and retain staff:	Services in a juvenile corrections setting Services in a child welfare system setting	40% 40%
Least difficult service location in which to recruit and retain staff:	No consistent response; mental health clinic based, school-based and hospital based all mentioned	
Most geographically understaffed area of State:	Rural	
Strategies:	None specified, except higher salaries	

Tennessee
No responses to this section.

<table>
<tr><th colspan="3">Texas</th></tr>
<tr><td>Most difficult type of service in which to recruit and retain staff:</td><td>Therapeutic foster care
Crisis services
Therapeutic group homes</td><td>29%
29%
29%</td></tr>
<tr><td>Why difficult:</td><td>Low salaries; long, irregular hours; high stress; high caseloads; excessive paperwork</td><td></td></tr>
<tr><td>Least difficult type of service in which to recruit and retain staff:</td><td>Clinic outpatient</td><td>29%</td></tr>
<tr><td>Why not as difficult:</td><td>More status, more like private practice</td><td></td></tr>
<tr><td>Most difficult service location in which to recruit and retain staff:</td><td>Services in juvenile corrections setting</td><td>29%</td></tr>
<tr><td>Least difficult service location in which to recruit and retain staff:</td><td>Mental health clinic-based and school-based</td><td>29% each</td></tr>
<tr><td>Most geographically understaffed area of State:</td><td colspan="2">Rural, especially South Texas and West Texas; also, small towns of less than 50,000</td></tr>
<tr><td>Strategies:</td><td colspan="2">None specified that currently exists, but several recommended strategies, including: mobile-home like arrangement for some staff to travel to rural areas on a rotation basis for about one week a month; incentives for staff to live and work in rural areas, such as company car, room and board, flexible hours, higher salary and benefits, better educational leave package and professional dues/licensure fee package -- perhaps offered to staff on a rotation basis, not permanent.</td></tr>
</table>

Major groups of respondents provided the following responses in this section--

Parents
Parents basically could not respond to the questions in this section. One parent said, "The whole state is understaffed in the child and adolescent area."

State Agency Officials

State agency officials also had difficulty, though certainly not as much as parents, responding to the questions in this section, citing the lack of data.

Most difficult type of service in which to recruit and retain staff:	In-home Therapeutic foster care Crisis services	43% 36% 36%
Why difficult:	No response	
Least difficult type of service in which to recruit and retain staff:	Clinic outpatient services	43%
Why not as difficult:	No response	
Most difficult service location in which to recruit and retain staff:	Services in a juvenile corrections setting Services in a child welfare system setting	57% 50%
Least difficult service location in which to recruit and retain staff:	Mental health clinic based Hospital based	43% 36%
Most geographically understaffed area of State:	Rural areas	
Strategies:	80% of State agency respondents did not identify strategies	

Local Service Providers

Local providers had slightly less difficulty than State agency officials in responding to this section.

Most difficult type of service in which to recruit and retain staff:	Crisis services In-home services Therapeutic foster care	50% 44% 31%
Why difficult:	No response	
Least difficult type of service in which to recruit and retain staff:	Clinic outpatient	44%
Why not as difficult:	No response	
Most difficult service location in which to recruit and retain staff:	Services in a juvenile corrections setting Services in a child welfare system setting	50% 50%
Least difficult service location in which to recruit and retain staff:	School-based Mental health clinic based	50% 38%
Most geographically understaffed area of State:	Rural areas	
Strategies:	67% of local providers did not identify strategies	

Advocates		
Advocates had the most difficulty after parents responding to this section.		
Most difficult type of service in which to recruit and retain staff:	Crisis services Respite services	100% 100%
Why difficult:	No response	
Least difficult type of service in which to recruit and retain staff:	Clinic outpatient Inpatient	20% 20%
Why not as difficult:	No response	
Most difficult service location in which to recruit and retain staff:	Services in a juvenile corrections setting	100%
Least difficult service location in which to recruit and retain staff:	No consistent response	
Most geographically understaffed area of State:	Rural	
Strategies:	Advocates did not identify any strategies	

Section IX Results

Section IX relates to the **relationship between the public child mental health system and the State's HRD capacity.**

Regionwide, 49% of respondents indicated that their respective State mental health agencies have an HRD office or other specific HRD capacity. 27% left this answer blank; 24% said that their State mental health agencies did not have an HRD office or other type of HRD capacity.

Regionwide, 43% of respondents said that their State's HRD office did not include a specific focus on child mental health workforce issues; 39% left this answer blank; 18% indicated that the HRD office did include a specific focus on children.

Regionwide, 49% of respondents left blank the answer as to whether their respective States have had an NIMH HRD grant; 31% indicated that their States have had an NIMH grant; 20% said no.

Regionwide, 55% left blank the answer as to whether their State's NIMH HRD grant included a specific focus on child mental health workforce issues; 29% said no; 16% indicated that their State's grant did include a focus on children.

Regionwide, 45% of respondents left blank the answer as to whether there was collaboration between their State's child mental health system and HRD office; 43% said no; 12% indicated there was collaboration.

In response to the question, "Who in your State has the major responsibility for child mental health HRD activities?", in only one State did the majority of respondents identify the HRD office; 3 States identified the children's system itself; in 3 other states, respondents left the answer blank; in 2 States, respondents said "no one", and in the remaining 2 States, responses were inconsistent.

In general, responses were inconsistent within States to all of the questions in this section.

By State, responses were as follows --

Alabama		
HRD capacity:	yes	
	no	50%
	left blank	50%
HRD capacity with child focus:	yes	
	no	25%
	left blank	75%
NIMH HRD grant:	yes	25%
	no	25%
	left blank	50%
NIMH HRD grant w/child focus:	yes	25% A CASSP grant was described, not an HRD grant.
	no	25%
	left blank	50%
Child MH/HRD Collaboration:	yes	25% Through P.L. 99-660 process
	no	25% "We don't even have a Director of child mental health services."
	left blank	50%
Responsible for Child HRD issues?		No consistent response. "Nobody; Dept. of Human Resources; Associate Commissioner of Mental Illness."

Arkansas		
HRD capacity:	yes	14%
	no	43%
	left blank	43%
HRD capacity with child focus:	no	14%
	left blank	86%
NIMH HRD grant:	no	14%
	left blank	86%
NIMH HRD grant w/child focus:	no	14%
	left blank	86%
Child MH/HRD Collaboration:	no	100%
Responsible for Child HRD issues?		CASSP or SMHRCY (57%)
Comments		"Our State does not have an HRD office; I have been involved in mental health system four-plus years [and] if we had an HRD office, it is well hidden so I would say it is not working with the system."

Georgia		
HRD capacity:	yes	71%
	no	14%
	left blank	14%
HRD capacity with child focus:	yes	14%
	no	43%
	left blank	43%
NIMH HRD grant:	no	43%
	left blank	57%
NIMH HRD grant w/child focus:	left blank	100%
Child MH/HRD Collaboration:	yes	43% For recruitment and hiring
	left blank	57%
Responsible for Child HRD issues?		No consistent response - 57% left blank

Kentucky		
HRD capacity:	yes	100%
HRD capacity with child focus:	no	100%
NIMH HRD grant:	yes	100%
NIMH HRD grant w/child focus:	left blank	100%
Child MH/HRD Collaboration:	no	100%
Responsible for Child HRD issues?		HRD office

Louisiana		
HRD capacity:	yes no	50% 50%
HRD capacity with child focus:	no left blank	50% 50%
NIMH HRD grant:	yes	100%
NIMH HRD grant w/child focus:	no	100%
Child MH/HRD Collaboration:	no	100%
Responsible for Child HRD issues?		SMHRCY (100%)

Mississippi		
HRD capacity:	yes	57%
	no	14%
	left blank	29%
HRD capacity with child focus:	yes	43%
	no	14%
	left blank	43%
NIMH HRD grant:	yes	43%
	left blank	57%
NIMH HRD grant w/child focus:	yes	29%
	no	14%
	left blank	57%
Child MH/HRD Collaboration:	yes	29% Training for residential workers
	no	14%
	left blank	57%
Responsible for Child HRD issues?		No consistent response; 57% left blank; other responses included both SMHRCY and HRD Divisions.

North Carolina		
HRD capacity:	yes	67%
	no	33%
HRD capacity with child focus:	yes	33%
	no	33%
	left blank	33%
NIMH HRD grant:	yes	33%
	left blank	67%
NIMH HRD grant w/child focus:	yes	33%
	left blank	67%
Child MH/HRD Collaboration:	no	33%
	left blank	67%
Responsible for Child HRD issues?		SMHRCY (67%)

Oklahoma		
HRD capacity:	yes no	67% 33%
HRD capacity with child focus:	yes no	33% 67%
NIMH HRD grant:	yes no	67% 33%
NIMH HRD grant w/child focus:	no left blank	33% 67%
Child MH/HRD Collaboration:	yes no	33% Help with conferences 67%
Responsible for Child HRD issues?		No consistent response.

South Carolina		
HRD capacity:	yes left blank	60% 40%
HRD capacity with child focus:	yes no left blank	20% 40% 40%
NIMH HRD grant:	no left blank	40% 60%
NIMH HRD grant w/child focus:	no left blank	60% 40%
Child MH/HRD Collaboration:	yes left blank	20% On personnel issues but nothing specific on recruitment, retention or training. 80%
Responsible for Child HRD issues?		20% "No specific entity or person" 80% Left blank

Tennessee
No responses to this Section

Texas		
HRD capacity:	yes left blank	71% 29%
HRD capacity with child focus:	yes no left blank	57% 14% 29%
NIMH HRD grant:	yes left blank	43% 57%
NIMH HRD grant w/child focus:	yes left blank	43% 57%
Child MH/HRD Collaboration:	yes left blank	43% Developed NIMH grant application together. 57%
Responsible for Child HRD issues?		No consistent response.

Major groups of respondents provided the following responses with respect to HRD capacity --

Parents		
HRD capacity:	yes no left blank	29% 43% 29%
HRD capacity with child focus:	yes no left blank	29% 29% 43%
NIMH HRD grant:	yes no left blank	29% 43% 29%
NIMH HRD grant w/child focus:	yes no left blank	14% Grants described were CASSP, not HRD 57% 29%
Child MH/HRD Collaboration:	no left blank	57% 43%
Responsible for Child HRD issues?		No consistent response.

State Agency Officials			
HRD capacity:	yes	71%	
	no	29%	
HRD capacity with child focus:	yes	36%	
	no	50%	
	left blank	14%	
NIMH HRD grant:	yes	71%	
	no	29%	
NIMH HRD grant w/child focus:	yes	50%	
	no	30%	
	left blank	20%	
Child MH/HRD Collaboration:	yes	36%	Most described limited collaboration, such as one-time training, assistance with personnel issues, assistance with workshops.
	no	36%	
	left blank	29%	
Responsible for Child HRD issues?		35%	Said "no one"
		29%	Identified CASSP or SMHRCY
		29%	Identified HRD Division
		7%	Left blank
		7%	Said shared between child mental health and HRD

Local Service Providers		
HRD capacity:	yes no left blank	56% 25% 19%
HRD capacity with child focus:	yes no left blank	25% 13% 63%
NIMH HRD grant:	yes no left blank	6% 13% 81%
NIMH HRD grant w/child focus:	yes left blank	6% 94%
Child MH/HRD Collaboration:	no left blank	6% 94%
Responsible for Child HRD issues?		63% left blank 24% no one 13% identified State mental health agency, CASSP or SMHRCY

Advocates		
HRD capacity:	yes left blank	40% 60%
HRD capacity with child focus:	yes no left blank	20% 40% 40%
NIMH HRD grant:	yes left blank	60% 40%
NIMH HRD grant w/child focus:	yes left blank	40% 60%
Child MH/HRD Collaboration:	left blank	100%
Responsible for Child HRD issues?		60% left blank 40% identified State mental health agency, CASSP or SMHRCY

Section X Results

Section X relates to **linkages between State mental health agencies and higher education** to address workforce issues.

Regionwide, 35% of respondents indicated that their respective States had some sort of linkage with higher education to improve the quantity and quality of staff for the public child mental health system. Most of the linkages described were limited or just beginning, and are described in the State responses below. 35% of respondents **regionwide** left this answer blank or said they did not know. 31% indicated that their States did not have linkages with higher education.

Regionwide, 65% of respondents either left blank or said they did not know the answer to whether their respective States wanted to establish linkages with higher education to address workforce issues in the children's system. 34% indicated that their States did want to establish such linkages; 0% said their States were not interested.

In response to an open-ended question, barriers to establishing linkages with higher education were described primarily as *lack of time, lack of resources (staff and dollars), lack of leadership and vision on the part of both State agencies and higher education, and lack of communication and understanding between the two sectors.*

By State, responses to the issue of State mental health agency-higher education linkages were as follows --

Alabama	
Linkages: yes left blank	25% "One collaborative project ... to develop and implement child mental health training series for CMHC workers." 75%
Does State desire linkages? yes left blank	 75% 25%
Barriers to linkages:	The State's educational system seems to think that they have more knowledge about providing education to all students, no matter what the disability. There is an unwillingness on their part to listen to the mental health system or families." "[Lack of] funding."

Arkansas		
Linkages: yes	43%	(1) State mental health agency contracted with University of Arkansas/University Affiliated Program to provide CASSP-related interagency case coordination training. (2) CASSP collaboration with University of Arkansas for Medical Sciences on rural mental health care research. (3) University of Arkansas-Little Rock offering advanced training for child protective services workers and providing off campus classes to facilitate more MSWs in rural areas.
no	29%	
left blank	29%	
Does State desire linkages:		
yes	14%	
left blank	86%	
Barriers to linkages:	"State agencies do not realize that highly trained/well qualified workers are needed to provide necessary services. They prefer to hire inexperienced, minimally educated staff. ...Our State does not seem to care that these persons are not competent to provide necessary services nor do they care that as a result of the stressors related to the job, these persons last an average of 6 months in these positions, which creates further gaps in already inadequate services." "Not enough time in the day."	

Georgia		
Linkages: yes	14%	Limited (some practica, and Georgia Mental Health Institute has some research ties with Emory University College of Medicine).
no	29%	
left blank	59%	
Does State desire linkages:		
yes	29%	
left blank	71%	
Barriers to linkages:	"Turf guarding and funding." "Accreditation organizations limit the type and number of courses that can be offered. If higher ed wanted to change curricula, it could likely lose accreditation. Students have few free electives that could be used for other coursework."	

Kentucky		
Linkages: yes	100%	Limited, not described.
Does State desire linkages: left blank	100%	
Barriers to linkages:	Time constraints.	

Louisiana	
Linkages: no	100%
Does State desire linkages:	
yes	50%
left blank	50%
Barriers to linkages:	"Time and money." "Organization and motivation."

Mississippi		
Linkages: yes	43%	(1) DMH staff works with higher education offering class presentations, curriculum development, faculty in-services, etc., to promote linkages (2) Child mental health system is establishing linkage currently with the Research and Training Center for the Handicapped at the University of Mississippi to do research.
no	43%	
left blank	14%	
Does State desire linkages:		
yes	57%	
no	43%	
Barriers to linkages:	"[Lack of] staff available to offer resources and budget cuts." "Lack of children's services, lack of awareness of the need and importance, lack of staff to coordinate the linkage ... the focus is on adult psychosocial rehabilitation." "It just hasn't been done. There are no real barriers. It just requires time and planning together. Of course, people on each end have to want to do it. This is true in schools of education and social work more than others. ..."	

North Carolina		
Linkages: yes	67%	(1) Several area mental health programs have graduate placement (MSW/Ph.D./MA) programs, M.D. fellowships, etc. (2) State mental health agency has been directly involved in helping to develop higher education curriculum for areas of service, such as in home and case management services at both the bachelors and graduate levels. (3) State mental health agency works with AHEC to expose medical/psychology/social work graduate students to community programs. (4) Linkage with East Carolina University Social Work/Child and Family Therapy Program, which has major grant and initiative for family preservation.
Does State desire linkages:		
yes	33%	
left blank	67%	
Barriers to linkages:	"Economic but by no means insurmountable."	

Oklahoma			
Linkages:	yes	33%	CASSP evaluation done by Oklahoma University
	no	33%	
	left blank	33%	
Does State desire linkages:			
	yes	33%	
	left blank	67%	
Barriers to linkages:		"Lack of cooperation/funding." "Politics, [lack of] knowledge"; lack of cooperation and funding. "Oklahoma is a young State where the issue of turf still is a big issue. Every agency and group has its own protected area with a legislative system that reinforces it. Linkages are hard. The poor economy for so long has made it worse."	

South Carolina			
Linkages:	yes	80%	(1) New S.C. Public-Academic Mental Health Consortium, made up of all major S.C. universities which offer degrees in mental health related fields, such as psychiatry, psychology, counseling, nursing, social work; also includes advocacy groups, such as Alliance for the Mentally Ill and Mental Health Association, and DMH staff -- currently an effort underway to educate the members about children's issues." (2) Center for Children's Policy at School of Social Work at University of South Carolina."
	no	20%	
Does State desire linkages:			
	yes	40%	
	left blank	60%	
Barriers to linkages:		"Understaffed central office." "Resistance to change, lack of faculty, lack of knowledge of job opportunities." "Lack of a mandate."	

Tennessee
No responses to this section.

Texas		
Linkages: yes	29%	(1) Some internships. (2) The interagency children's mental health plan has a research/evaluation component which is developing an academic advisory group.
no	29%	
left blank	43%	
Does State desire linkages:		
yes	29%	
left blank	71%	
Barriers to linkages:	"We really need more creative thinking in the public sector and in universities in this respect."	
Recommendation:	Have a paid professor/consultant work collaboratively with a local/State individual to stay apprised of public service needs and help to recruit faculty and students to address these needs, be they staff-related, research-related or resources, such as libraries, computer center. Also, faculty could train staff in-house to take on responsibilities independent of the university, such as research. This kind of endeavor could be set up as a paid leave for a professor, e.g. 'public service fellow'.	

Major groups of respondents provided the following responses with respect to linkages --

Parents

80% of parents believe there are no linkages or do not know. Most believe States want linkages. Parents offered many comments regarding barriers to establishing linkages, tending to cite a lack of leadership on the part of both State agencies and universities.

State Agency Officials

36% indicated there are no linkages in their respective States. 29% said linkages were limited. 29% said there are linkages, and 6% described beginning linkages with potential.

State agency officials had few comments regarding barriers to establishing linkages. Of those who did, 73% cited lack of time and resources (staff and money) as the major barriers.

Local Service Providers

81% of local providers believe there are no linkages or do not know. Most left blank or said they did not know whether their respective States want to establish linkages with higher education.

Local providers had many comments regarding barriers to linkages, tending to cite turf issues and lack of awareness, as well as lack of resources and time.

Advocates

60% of advocates left this answer blank. 40% indicated there are linkages between mental health and higher education in their respective States.

Advocates did not have many comments regarding barriers to establishing linkages; those who did tended to cite lack of commitment or a mandate.

Overall Comments

In the final section of the survey, respondents were given the opportunity to provide any additional information or comments that would help to shed further light on HRD issues in their respective States. 43% of parents and 43% of local service providers offered additional information; a few comments came from State agency officials as well.

The following are excerpts from parents' comments that are representative of parents' comments in general --

> *"The State Department of Mental Health is not child or family oriented so that the administration does not...provide much support for the Division of Children and Youth. Turf issues, who will get the 'glory' and finances are all crucial factors inhibiting effectiveness."*

> *"The biggest barrier is in the education of the mentally ill child. The federal guidelines for emotional conflict are arbitrary and vague...Each State must...improve upon them. Educators do not understand the illness or needs of the child and family.. until the educational system is willing to work with other agencies, the future success for these children is non-existent... People who work with mentally ill children need hands-on experience. I find I do more educating of many of the professionals... We need so many services that are non-existent (and) so many people who are caring, professional and knowledgeable. It is essential that the public becomes informed and educated about mental illness (and makes) a united demand for care."*

> *"Our children are getting the short side of mental health treatments...while we have an excellent school of medicine, the chairman of the psychiatric department encourages his students into research, giving them a difficult time when they want to go clinical. Our children are falling through cracks...CASSP is working on some, but...there were to be*

regional CASSP teams, consisting of 51% parents...after the profit and non profit folks got together and decided what we parents and our children needed, they invited us to see what they had done and endorse it...but we were not given voting rights, we were considered guests. The system is going to have acknowledge our children have rights to...services that fit their needs and that parents are mainly the professionals.

"A large number of parents have had to give custody to the State to get services for their children...So many who work with our children don't understand, don't know about true emotional disturbance; they only seem aware of behavior problems...If we will seriously begin early identification and prevention, maybe we won't have so many behavior problems...We have a small spark of hope (with passage of CASSP-like legislation by the State), but the legislature has not funded (it)".

The following are excerpts from local service providers that are representative of local providers' comments in general --

"The major problem related to the delivery of community-based services for children and adolescents with serious emotional disturbance is the negative mindset of staff at all levels of State, as well as private, agencies. Essentially, we have been dependent upon hospital and residential treatment."

"(Our State's) children and youth services are beginning to get established...the interagency approach on the State and local level is encouraging. Also, in home, family preservation services, particularly those collaboratively implemented by MHMR and juvenile probation departments, is a favorable development. Increased experience regarding staffing needs in children's programs and needs for continued recruitment of qualified staff, retention and staff development will strengthen these services. "

"(Our State) occasionally shows some real creativity in dealing with difficult populations. The major problem is that there is a huge need because of the poor economy, few insured and extreme competitiveness among State agencies for limited dollars. Usually mental health scores low in funding because it is still not seen as a high priority by (our citizens)."

"(The main issues are) lack of funding to delivery community-based services, low reimbursement, lack of interest to develop children's services, lack of knowledge and qualified staff."

"A plan has been developed by our State C & A mental health office to address many of the issues stated in this questionnaire, but it has never been implemented (because) service priority (is with) the most-in-need, chronic mentally ill adult population and (because of) the Governor's decision to downsize State employee numbers. Due to these developments, our C & A mental health staff has had an extremely difficult time in providing just minimal services. Additional (children's) staff and training opportunities have all but vanished over the past eight years. The original plan is a good one."

"(Major issue is) ...increased funding to reduce staff workloads."

> *"As a local program, we have focused strongly on staff support, training and retention -- with support from the State. Our longevity record for child staff is quite strong. In part, this is also due to the support for expansion in services, due to consistent efforts by the State child office to get support in both public (legislature) and private (grants) areas. The expansions have allowed us considerable 'vertical mobility' for many good staff. The fairly constant challenges of opening into new service areas (like family preservation, crisis nursery, etc.) have also proved quite attractive to the staff themselves."*

The following are representative comments from State agency officials --

> *"We are hoping that the old 'Training of Trainers' (model) will work better for us than other traditional training schemes due to shortages in people power available for training."*

> *"I am very concerned about thousands of students who are trained in our public universities -- which means their education is subsidized by taxpayers -- who then enter the private sector. It seems pretty stupid that State agencies tolerate this. Persons who are trained in public universities ought to be required to practice in non profit settings...as part of a payback for the piece of their education that was supported by taxpayers."*

SECTION V. DISCUSSION OF SURVEY RESULTS

A. Where States Are Heading

There is a high level of awareness across all the States and among all types of respondents about the directions in which States are heading, and there is remarkable consistency in State priority areas. Large majorities of respondents describe their States moving to develop more and new types of community-based services, joint initiatives between mental health and other child-serving systems, new financing mechanisms, State and local interagency coordinating bodies, family support programs and culturally competent services. These new directions represent a major departure in service delivery for children and adolescents with serious emotional disturbance/mental illness and their families, and thus raise critical issues for the workforce -- for administrative and clinical staff alike.

- More community-based services mean more staff are needed, yet severe personnel shortages exist, especially in certain disciplines, such as child psychiatry, and in certain areas, such as rural communities.

- More and new types of services entail development of knowledge about new staffing requirements, yet there seems to be a minimal body of knowledge on which to draw in the region.

- New types of services, and new ways of organizing and delivering them, such as involving families in meaningful roles, require staff with the appropriate knowledge, skills and attitudes, which entails training, re-training and changes in academic preparation, yet State-university linkages are minimal and funding for in-service training is scarce.

- Joint initiatives between mental health and other child-serving systems, and the development of State and local interagency coordinating bodies, suggest a critical need for staff with interagency competencies, as well as collaborative training across systems.

- Culturally competent services place demands on mental health agencies to develop/expand new linkages with such organizations as historic Black colleges and universities, indigenous community-based organizations, professional associations representing persons of color and the like, to recruit more creatively, develop new training programs, etc.

- Many of the new types of services, such as in-home services, are those where respondents indicate States have the most difficulty recruiting and retaining staff, suggesting the need for very targeted recruitment and retention strategies.

While all of the States in the region are moving in similar directions, survey responses also would indicate that some States are further along than others or engaged on more multiple fronts. Respondents in North Carolina, for example, indicate State activity in virtually all new directions listed in the survey, while other States, such as Oklahoma and Alabama, indicate concentrated activity in just a few areas. If indeed some States are more experienced in a wider array of areas, opportunity exists for targeted peer-to-peer technical assistance and resource-sharing among States in the region.

It should also be noted, as indeed one respondent did, that, while the new directions in which States are heading pose HRD challenges, they also create opportunity. Very often, movement in new directions, if managed and marketed effectively, creates incentive for good staff to become and remain involved in public systems.

B. Concern About HRD Issues

Survey responses would indicate a very high level of concern throughout the region about HRD issues. A solid majority of respondents (69%) consider HRD issues to be as or more critical than funding to the implementation of community-based systems of care for children and families. This solid majority held for every major type of respondent, except advocates, who split as to whether HRD was more or less critical than funding. (This is probably not surprising given the focus of advocates, in general, on funding policies.) Local providers had the largest majority (87%) rating HRD issues as or more critical than funding. This, too, seems unsurprising, given the day-to-day proximity of local providers to workforce concerns. Solid majorities of parents (72%) and state officials (78%) also rated HRD more or as critical as funding. This was true in every State as well, except Texas (where a majority of respondents rated HRD as less critical than funding).

Respondents are concerned about a wide variety of HRD issues. For example, when asked to check and rank overriding HRD issues from a list, respondents checked and ranked every possible issue. Respondents prioritized these issues as follows --

(1) ability to recruit appropriately trained staff
(2) achievement of the desired geographic distribution of staff
(3) achievement of desired racial, ethnic and cultural diversity among staff
(4) adequate in-service training
(5) retention of staff
(6) lack of sufficient knowledge about staffing requirements
(7) ability to recruit sufficient numbers of staff
(8) having sufficient capacity in the State to assess, address and track HRD issues.

Only the first -- ability to recruit appropriately trained staff -- emerged as a priority concern among a majority (61%) of respondents. In addition to being cited by a majority, this issue was identified as the number one concern by every major type of respondent, except parents (who ranked it #2), and in every State, except Texas (which did not rank it among its top three concerns). It is clear from later parts of the survey that concern over ability to recruit appropriately trained staff is integrally tied to the perception that university curricula are not relevant to State priority areas, that not enough of those who are being trained have the requisite knowledge, skills and attitudes and that not enough of those being trained are entering public systems. It also is tied to the fact that, in many States in the region, child mental health systems must rely on staff from the adult system, who do not have the necessary training in children's services.

Parents were the only major respondent group to rank as a top three HRD issue, ability to recruit sufficient numbers of staff (Although many respondents did check this as an issue, only 12% ranked it as a top three concern). Parents' concern about sufficient numbers of staff may reflect concern over the shortage of services in general; indeed, parents' comments often cite a lack of services.

C. Knowledge About Staffing Requirements

Survey responses indicate both a great deal of uncertainty, as well as pessimism, as to the state of knowledge in the region about staffing requirements for community-based services for children and families. Most respondents do not know if there is adequate knowledge in their States, or they do not think there is. This was true of respondents in all States, except North Carolina and Kentucky, where respondents do believe there is adequate knowledge.

Respondents prioritized the areas where they believe there is the least amount of knowledge, or where they are most uncertain as to what knowledge does exist, as --

- distribution of staff (i.e. where and how staff should be deployed) - only 27% of respondents felt there was adequate knowledge on this issue
- mix of staff needed - only 31% of respondents felt there was adequate knowledge
- numbers of staff needed - only 37% felt there was adequate knowledge
- types of staff needed - only 39% felt there was adequate knowledge
- skills required - this was the area respondents were most likely to identify as the one where adequate knowledge exists, with 43% of respondents saying there was adequate knowledge (parents and advocates were the least likely to say that adequate knowledge exists about skills required).

Parents and advocates were the most uncertain as to what knowledge exists in general. State agency officials were the most certain of their responses, but also the most pessimistic, with a very high percentage -- 79% -- saying there was not information available in their States that would be useful to other States in the region.

Given that there is not HRD capacity related to child and adolescent systems in most States in the region (as indicated later in the survey), and that, in many States, children's systems are at an early developmental stage, it is not surprising that little knowledge exists about staffing requirements.

D. Staff Shortages

Not surprisingly, a very high percentage of respondents (80%) believe there are staff shortages. More surprising, however, is that those surveyed believe shortages exist in every discipline and type of staff; however, with the exception of child psychiatry, there is considerable variation among the States and some variation by type of respondent. Child psychiatrists are in short supply in every State, except, apparently, North Carolina. Beyond that, however, types of shortages differ considerably by State.

It is not possible from this survey to determine why perceptions of shortages vary from State to State, as well as among types of respondents. Parents, for example, are the only major group to indicate that adjunctive therapists, such as music and art therapists, are a priority shortage area. (One could speculate that this might reflect parents' difficulties in accessing adjunctive therapy services through the public system, as much as it might reflect a true shortage in this profession.) Also, and not surprisingly, a much higher percentage of parents than other respondent groups rank "parents in staff roles" as a major shortage area (43% of parents ranked this as a critical shortage area, 29% of State agency officials, 20% of advocates and only 13% of local providers). Advocates are the only major group to indicate a shortage of psychiatric nurses. (Indeed, for the most part, psychiatric nurses are not ranked as a high shortage area, perhaps because respondents do not associate nurses with community-based services). Arkansas is the only State to identify MSWs as a priority shortage area, and Kentucky the only State to identify paraprofessionals. As noted earlier, North Carolina is the only State to not identify child psychiatrists as a shortage area. One could speculate that this might be because North Carolina is a State with a number of medical colleges, with which the State has developed strong linkages, or it may be because the State is relying less on child psychiatry in its community system, or because its salary structure for child psychiatrists is competitive with the private sector, or any number of other reasons. These issues require further exploration to move beyond speculation; further study may also yield information about effective approaches to alleviate staff shortages.

Shortages are clearly related to funding in all States, except, apparently, North Carolina, with the majority of respondents indicating that the major reasons for staff shortages are insufficient funding to hire staff and low salaries. (Neither of these reasons was cited as a major concern by North Carolina respondents, who were far more concerned over insufficient numbers of persons being trained and entering the public system). The next reasons most frequently cited (by over a third of respondents each) relate to training deficiencies - i.e. that insufficient numbers of persons are being trained and an insufficient number of those who are trained are entering public systems. Consensus around additional reasons, such as undesirable geographic area, drops to 8%.

Both major sets of reasons -- those related to funding and those related to training -- have implications for strategies to alleviate shortages, such as revamping salary structures or embarking on public awareness campaigns to encourage entry into child and adolescent fields. However, few strategies were cited by respondents, and most related to efforts to increase overall funding for children's services. Again, given the early developmental stage of children's systems in most States, and the lack of a Statewide HRD focus on children, this does not seem surprising.

E. Inappropriately Trained Staff

As noted earlier, the issue of adequately trained staff is a major one in the region. Large percentages of parents (100%), State agency officials (86%) and advocates (100%) indicate that their States do not have access to appropriately trained staff. Local providers were not as likely to indicate concern over access to appropriately trained staff, although still a majority (56%) did so. Local providers also differed from the other major respondent groups in their identification of the major areas where inadequate preparation was especially a problem. The two major areas cited by all of the other respondent groups were: 1) working with families and 2) understanding emotional disturbance in children and adolescents. Neither was cited as a major problem area by local providers, who tended to cite more specialized concerns, such as working with sexual offenders. Again, one can only speculate, at this point, as to the reasons for these differing perspectives on the part of local providers. It may be, for example, that system of care concepts that have taken several years to develop at State levels are only just beginning to move to local levels. The issue is potentially troubling, however, if it suggests local providers are less in touch with fundamental system issues, particularly in the case of working with families.

F. In-Service Training Needs

Survey responses would indicate there is a consistently high level of concern in every State and across all respondent groups about the need for in-service training. Consistent with their responses in the previous section related to academic preparation, however, local providers do not have the same perceptions as parents, State agency officials or advocates as to the most important new skills that are needed. All other respondent groups indicate that working with families and understanding new community-based treatment modalities and the system of care concept are the most critical areas where new skills are needed. Neither is an area cited frequently by local providers. Local providers also do not cite interagency competencies as a critical area, which both State agency officials and advocates do. Again, while one can only speculate, these differing perceptions on the part of local providers are troubling in that they seem to suggest a certain lack of understanding as to State (and parent) priority concerns.

Local providers also differ markedly from parents and State agency officials regarding their perception of the need for in-service training because staff have inappropriate attitudes. 100% of parents and 71% of State agency officials rank this a "10", while only 38% of local providers gave this a 10. All major respondent groups except local providers cited staff attitudes toward families, such as blaming families or acting paternalistically, as a major concern.

Most (68%) respondents say there are not adequate in-service curricula, training methods or training personnel available. The major reason for this unavailability seems to be lack of funding to do training (cited by 53%), rather than an absence of curricula (cited by only 31%). While responses indicate there are gaps in curricula in some States and in some subject areas, it also is clear from responses, particularly regarding strategies, that major pieces of relevant curricula do exist, such as in the areas of working with families, interagency skill-building, case management, CASSP system of care concepts and many of the new treatment modalities, such as in-home services, that could be implemented on a wider scale if funding were available.

The majority (57%) of respondents rank their States low on the extent to which they are doing in-service training, yet, at the same time, respondents were far more likely to identify strategies related to in-service training than to any other HRD area.

G. Recruitment and Retention Issues

The fact that, according to respondents, State systems rely heavily on higher education and, in many cases, on adult mental health staff to fill positions in the child mental health system reaffirms points made earlier about the need for effective State-university linkages, as well as systematic orientation and training for adult staff. Responses also indicate reliance on staff from other public child-serving systems, such as child welfare, and suggest that staff also go to other child-serving systems when they leave mental health. This traffic among child-serving systems suggests the utility of an interagency approach to HRD issues in the children's area.

Responses would indicate some variation among States as to the extent they rely on adult mental health staff. Respondents in Alabama and Oklahoma indicated that the highest percentages of staff in their States are drawn from the adult system; Kentucky, North Carolina and South Carolina, on the other hand, indicated no reliance on the adult system.

It is also interesting to note from where staff are not drawn, according to respondents. The three areas least likely to be cited as places from which public systems draw staff are: private for profit sector, higher education faculty and parents.

While staff may not be coming from the private, for profit sector, it is clear that respondents believe staff leave the public system for the for profit world. This one-way traffic raises issues for both sectors -- for example, are public systems serving as "training grounds" for the for profit sector, with no reciprocal benefit; how can public systems make themselves more attractive to those in the for profit sector; what is the responsibility, if any, of the for profit sector to the public system?

The lack of staff drawn from higher education faculty, as well as the small numbers of public system staff who go to higher education faculty positions from the public system, are additional factors in the gap that exists between higher education and public child systems.

The absence of parents in staff roles is also a cause for concern. If understanding and working with families is a major issue among States, as has been noted, it would seem that involvement of parents in meaningful staff roles, much like adult systems have begun to involve consumers in staff roles, would be an additional step States can take to foster understanding, reduce the isolation that families feel and enhance the skills of providers and parents alike.

There was a great deal of consistency across the region that most staff drawn from higher education are coming from in-State, public colleges and universities, which would suggest opportunity both within States and regionwide to target land grant universities, which have a responsibility to meet public sector needs.

Not surprisingly, clinicians were cited as the most difficult type of staff both to recruit, as well as retain, and child psychiatrists, the most difficult discipline to recruit as well as retain. The consistency in responses with respect to child psychiatrists suggests a need for regionwide strategies to recruit and retain child psychiatrists. Beyond child psychiatrists, however, there is variation across the region as to which disciplines States feel are most difficult to recruit and retain, with virtually all cited by some number of respondents. Generic recruitment and retention approaches might be most useful to disseminate regionwide.

There also was variation across the States with respect to which types of services were the most difficult to draw staff to, although the most frequently cited was in-home services, which also was most frequently cited as the most difficult in which to retain staff. On the other hand, clinic outpatient services were cited as the least difficult in which to both recruit and retain. This is not surprising, given that in-home services is a new, demanding and non-traditional component, while clinic outpatient is a known quantity with, typically, regular office hours. However, it is a major cause for concern, given that in-home services was reported to be among the top three new community-based services States are seeking to develop. There is a regionwide need for specialized recruitment and retention strategies geared to in home service components.

While respondents had difficulty answering both recruitment and retention questions, responses about retention were especially "all over the place", reflecting not only the general lack of data, but lack of experience as well since children's systems are so new in many of the States. According to respondents, staff leave public child mental health systems for a variety of reasons, and combinations of reasons, with no one reason being paramount.

Responses suggest that, in most States, there is minimal systematic attention devoted to recruitment and retention issues, nor is there a structure at State levels to focus on these concerns beyond the traditional State personnel agency, which most respondents describe as marginally effective at best. On the other hand, were States to develop such a focus at State levels, there are many good recruitment and retention ideas at the local level that might be implemented on a Statewide basis.

H. Distribution Issues

As with recruitment and retention, responses related to distribution would indicate that States either do not have enough of a track record with community based services for children, or do not have the HRD capacity, to have acquired a body of knowledge on the topic. In addition, in some States, as one respondent noted, "The entire State is understaffed with respect to services for children and adolescents".

Perceptions in the region, however, are that the newer types of services -- i.e. crisis services, in-home and therapeutic foster care -- are the most difficult to staff and keep staffed, and the more traditional components, such as clinic outpatient services, the least difficult. Similarly, the less traditional locations for provision of mental health services, such as juvenile corrections settings and child protective services intake, are more difficult to staff and keep staffed than are the more traditional settings, such as a mental health clinic, hospital or school. Reasons for this greater difficulty were consistent and included such issues as greater levels of stress and higher caseloads, longer, more irregular hours, inadequate training and supports, low pay and personal safety concerns. Responses suggest a need for HRD strategies targeted to the newer types of services and settings, including pay differentials, specialized training, smaller caseloads, more intensive on-the-job supports and back-up systems, "time-out" periods through rotation into other assignments or time off, etc.

Not surprisingly, rural areas were identified as the most geographically understaffed in the region, posing challenges for every State. Small communities and inner cities also were cited as understaffed, but less so, and, in the case of inner cities, responses would indicate that retention is more of an issue than recruitment. Again, targeted HRD strategies are needed; the Community Support Program (CSP) in adult services, which is a decade older than the child and adolescent community-based services movement, may offer examples of strategies to encourage staff to go to and remain in rural areas that could be adapted by the children's system.

I. Child/Adolescent HRD Capacity Issues

Responses with respect to a State's capacity to address HRD issues related to child mental health services suggest that most States in the region have little to no capacity in this regard. Only 18% of respondents indicated that their respective States have an HRD focus on children. Only 16% indicated that their States have received an NIMH HRD grant targeted to child workforce concerns (even that 16% may be overstated, as some of the grants described were, in reality, CASSP grants). Only 12% indicated that there was collaboration between their State's HRD office and the child and adolescent system. Respondents also are unclear as to who has the major responsibility for child mental health HRD activities in their respective States.

Parents and local providers had the most difficulty responding to the questions in this section, suggesting that, even if a State does have an HRD capacity and focus on children, large groups of key stakeholders do not know about it.

If States fail to develop a Statewide, systemic focus on child system -related HRD issues in the face of State movement toward community-based systems of care and the major HRD implications that entails, there is a danger that each local community will struggle on its own to address these issues, creating fragmentation, duplication of effort and unnecessary delay in implementing services. There also will be considerably less opportunity for States within the region to assist one another in addressing these concerns.

J. State-University Linkage Issues

Only about a third of respondents indicated that their States have linkages with higher education to address workforce issues in the children's area, and most of these were described as just beginning or of limited scope. Neither States nor universities are described as having taken the leadership to bridge the gap that clearly exists between the two sectors.

Community-based systems for children simply cannot be effectively implemented with insufficient numbers of staff who lack the requisite skills, knowledge and attitudes; indeed, this may be the single most critical issue facing State child mental health systems in the decade ahead.

Respondents clearly feel that universities are not playing a role in encouraging persons to train in child mental health related fields, nor to enter public systems if they do, nor are universities working to ensure that curricula and practica are relevant to public system needs. By the same token, respondents also clearly believe that States are not exerting the leadership to engage and support universities to help meet public sector demands. Even the relatively painless step of establishing a dialogue seems not to have occurred in most States in the region.

Again, experience from the adult side with the CSP movement may yield generic strategies for State-university linkages that are transferable to the children's area. Given the staff movement among child-serving systems and State foci on interagency system development, an interagency approach to developing linkages also seems to make sense. As suggested earlier, a logical starting point for States to develop or strengthen linkages is with public colleges and universities, which, according to respondents, are supplying the majority of staff to public systems and which, in the case of land grant universities, have a mission to support public needs.

SECTION VI. RECOMMENDATIONS/FUTURE DIRECTIONS

In contracting for the children's needs assessment, the Southern HRD Consortium also requested recommendations for possible next steps it could take to assist States in the region with workforce issues related to the child and adolescent system. As much as possible, the recommendations offered below envision the Consortium's taking a systemic approach to workforce issues, that is, focusing on issues that pose regionwide, systemic barriers to effective implementation of community-based services for children and adolescents and their families, and exploring regionwide, systemic solutions. (Note: These recommendations are "budget-neutral", that is, they do not take into account whether the Consortium has the resources to implement them, as this information was not part of this study) --

- There is widespread concern among survey respondents about the appropriateness and relevancy of higher education training. Curricula changes are needed; greater opportunity for students to do practica and internships in the public sector; greater opportunity for faculty to spend time in public systems and for state/local providers and parents to spend time in university classrooms as lecturers and adjunct faculty. Universities, and particularly public institutions of higher learning, need to be connected to the systems change initiatives underway in States in the region; and, State systems, including parents, need to be actively involved in ensuring that university teaching, as well as research, is relevant to the directions in which systems are heading. There needs to be a coordinated approach between universities and State systems to ensure an adequate children's workforce. That approach cannot be developed unless communication and understanding is strengthened between the two sectors, which requires leadership.

The Consortium could play a leadership role in bringing together State and local officials, providers, parents, other key stakeholders and university representatives in the region to highlight child workforce concerns and explore common ground for addressing them. The Consortium could facilitate this dialogue through regional conferences and workshops , as well as "summit meetings" between State mental health commissioners/SMHRCY representatives and key university deans and program chairs. Conferences could not only highlight the issues but focus attention on strategies that might be implemented regionwide -- as well as in individual States. Regional conferences and summit meetings also could serve as models for similar initiatives at individual State levels.

- There is a high level of concern throughout the region that too few persons are entering training programs related to child and adolescent mental health services and too few who do enter these fields who take jobs in the public system. Public awareness campaigns are needed, in the community at large and on college campuses, to raise the level of consciousness about children and adolescents with serious emotional disturbance/mental illness and their families and the opportunities that exist in public systems, particularly those undergoing innovative change.

The Consortium could embark on both a regional public awareness campaign, as well as develop public service announcements, videos, educational material and the like that could be utilized by States in the region (without each State having to develop its own materials, which would be inefficient). The CASSP Technical Assistance Center at Georgetown University developed similar "generic" public awareness materials for use by States when the CASSP program was in its early years and perhaps could be helpful to the Consortium in this regard. Additionally, the Child Welfare League of America, with support from the U.S. Department of Health and Human Services, has launched a public awareness campaign to encourage persons to enter the child welfare field. The League might be helpful to the Consortium and, in any event, the child welfare and child mental health fields should be working cooperatively in this area.

- Many of the workforce issues in the child mental health field also are concerns in the other child-serving systems, such as child welfare and juvenile justice, and, as survey respondents pointed out, there is considerable movement of staff among children's systems. Again, it is inefficient and duplicative for each child-serving system to struggle on its own to address what, in many cases, are the same issues. A coordinated, interagency approach to child workforce issues is needed.

The Consortium could play a leadership role in bringing together its counterparts in other children's areas, if such entities exist, to develop coordinated strategies. The Consortium also could explore, on behalf of the region, whether other child-serving systems are involved in workforce-related initiatives on a systemic level, such as those in which the Child Welfare League is involved, that offer opportunities for coordinated approaches. Other child-serving systems also should be partners in efforts to engage higher education.

- While survey respondents indicate a paucity, in general, of HRD strategies related to the children's system, there are some exceptions, particularly in the area of in-service training and curricula development and, at the local level, with respect to recruitment and retention strategies (or, at least, good ideas). There also are, no doubt, HRD strategies that have been developed for the adult system (the CSP movement, in particular) that would be useful to the children's system.

The Consortium could play a very useful role as a facilitator of peer-to-peer technical assistance among States in the region, bringing together those States that have developed effective HRD strategies in either the child or adult areas with those that need assistance. The Consortium also could serve as a regional information clearinghouse for effective HRD approaches and materials.

- One area in which to begin systematically identifying resource materials and people is that of curricula. Respondents make it clear that States within the region are heading in very similar directions in the development of community-based systems for children and families. A number of States already have developed training curricula relevant to various components in a system of care; for example, Texas is developing an interagency competencies curriculum and curricula related to community-level case assessment and case management; North Carolina is developing curricula for intensive case management services and for family empowerment; Mississippi has curricula related to utilizing parents as partners, interagency collaboration, cultural competency and case management; Kentucky has developed staffing requirements for case managers, intensive in-home services, wraparound service aides and therapeutic foster care. There undoubtedly are others both in the region and, certainly, nationally.

The Consortium could systematically identify relevant curricula to ensure that States do not reinvent the wheel and, at the same time, to identify where gaps still exist; and, the Consortium could "package" and disseminate these curricula in ways that are useful to States in the region.

- With the combination of the children's system relying on staff redeployed from the adult system, as well as on students who are not adequately prepared, there is, as survey respondents reaffirm, a need for effective in-service training. At the same time, respondents point out that lack of funding is the major barrier to in-service training, a situation that is unlikely to improve in the next few years, given the economic situation of most States.

The Consortium could explore regional approaches to the issue of in-service training that might be more efficient than individual State solutions. The identification and dissemination of curricula mentioned above is one such approach in that it saves individual States from having either to track down examples or develop material on their own. Identification of a corps of trainers which States could tap into, perhaps with the Consortium subsidizing some of the cost, is another possibility, particularly if this core group of trainers takes a "train the trainers" approach at the State level. Another approach at least to explore is development of a regional training institute, perhaps in partnership with a coalition of institutions of higher education. Such an institute is relevant to the issue of pre-service training as well (as, indeed, are all of the in-service training suggestions). One caveat about creation of a regional training institute for in-service training is if it depends primarily on individuals' being able to travel to it, it is clear from survey responses that inability to travel, either because of lack of funds or time, is an impediment to in-service training even within States, much less between them.

- Based on the survey results, it would appear that there is limited knowledge about the staffing requirements for community-based services -- i.e. numbers of staff needed, mix, distribution, etc. in the region, or, at least, it is unclear what knowledge does exist.

The Consortium could take a closer look at this area to catalog and disseminate information about what is available and identify and fill gaps. Through targeted workshops, again using peer-to-peer technical assistance, as well as outside assistance, if needed, the Consortium could assist individual States in the region to understand their staffing requirements.

- It is clear from survey responses that a major concern in the region is meaningful involvement of families in systems of care, which respondents indicate entails changing attitudes and the way individuals are trained, acquisition of new skills by parents and professionals alike and fostering a deeper understanding of what emotional disturbance is in children and adolescents and what it means for their families. Survey responses also seem to suggest that the biggest gap in understanding and working with families is at the local provider level.

The Consortium, in partnership with regional and/or national families' groups, such as Federation of Families, the Alliance for the Mentally Ill-Child and Adolescent Network and State groups, could play a leadership role in ensuring that the family "movement", much like the consumer movement *on the adult side, becomes an integral part of HRD strategies throughout the region. This will require, in the first instance, consciousness-raising, particularly at the local level within States and, secondly, identification and dissemination of effective ways of involving families in the HRD area, such as families assuming paid staff roles, families as teachers in pre and in-service training programs, families having roles in public awareness and recruitment campaigns, families serving on task forces to assess workforce issues, etc.*

- Survey responses indicate that equitable geographic distribution of staff, particularly in rural areas, is a major concern regionwide.

The Consortium could play a role in identifying incentives that are in use in other areas, for example, on the adult side, or in the private sector, that might be adaptable to the children's area.

- Respondents also indicate that States are having difficulty getting staff to go to and remain in non-traditional service settings, such as juvenile corrections and child protective services locations.

The Consortium could sponsor interagency forums between mental health and these other child-serving systems to explore incentives that could be offered conjointly.

- It is clear from the survey that in-home services is a major direction in which States in the region are heading, and respondents suggest it also may be the most difficult component in which to recruit and retain staff.

The Consortium could form a task force of state and local representatives and parents and give it the charge of identifying for the region effective recruitment and retention strategies for in-home service components. The work of the task force could build on a systematic identification of whether other States or other systems, such as child welfare, have developed effective recruitment and retention strategies in this area.

- Recruitment and retention initiatives directed toward clinical staff are a need throughout the region.

The Consortium could play a valuable role in identifying and disseminating information about effective recruitment and retention strategies in general, particularly because most States do not seem to have an HRD capacity (see below) and those involved in implementing the children's system are not HRD experts.

- Child psychiatrists pose the biggest recruitment and retention challenge throughout the region, except in North Carolina.

The Consortium could explore whether North Carolina is engaged in strategies that might be utilized by other States (beyond the issue of salary structures), if, indeed, recruitment/retention of child psychiatrists is not an issue in that State. Also, the Consortium could play a leadership role in beginning a dialogue with medical colleges, medical societies and professional associations to explore approaches to increasing the numbers of persons entering child psychiatry in the region.

- Among the major directions in which States are heading is development of culturally competent services, and respondents also indicate that ability to recruit professional staff of color is a concern throughout most of the region.

The Consortium could play a leadership role in convening a forum with historic Black colleges and universities in the region, of which there are a number, as well as with organizations representing other racial and ethnic minorities, and start a process to involve those institutions in training and in recruiting and preparing students to enter public systems.

- It would appear from survey responses that there are a number of States in the region that have no HRD capacity at all, and that most have no capacity focused specifically on children's workforce issues. Those involved in implementing children's systems are not HRD experts, and those involved in HRD issues at State levels, primarily State personnel agencies doing traditional kinds of personnel functions, are not children's services experts. If child workforce issues are to be addressed, there either has to be created a "children's specialty" in State HRD offices (assuming there is an HRD office) or an "HRD specialty" within children's systems. Which approach makes sense no doubt varies from State to State, and in either case, in most States, will require greater awareness about HRD issues and their relevancy to implementation of the children's system.

Again, the Consortium could play a leadership role in educating States in the region about the importance of HRD issues to the children's system and assisting States to determine the most effective structures for incorporating an HRD focus in the children's area. The Consortium could begin by bringing together State HRD representatives and SMHRCY representatives to launch a process for achieving mutual understanding and for developing strategies for each State to create a child HRD capacity.

REFERENCES

Behar, L. (1985). Changing Patterns of State Responsibility: A Case Study of North Carolina. *Journal of Clinical Child Psychology,* 14:188-195.

Isaacs, M. (1984). *A Technical Assistance Package for the Child and Adolescent Service System Program, Volume 1.* Rockville, MD: Office of State and Community Liaison, National Institute of Mental Health, Alcohol, Drug Abuse and Mental Health Administration, Public Health Service, U.S. Department of Health and Human Services.

Knitzer, J. (1982). *Unclaimed Children.* Washington, DC: Children's Defense Fund.

Kravitz, S. (Summer 1991). Professional Social Work Education and Public Child Welfare: Where Do We Stand? Where Are We Going? *Future Choices,* Vol. 3, No. 1.

National Institute of Mental Health. (September 1992). *Human Resource Development Program, National Task Force Strategic Plan.* (Draft Report). Rockville, MD: National Institute of Mental Health, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, U.S. Department of Health and Human Services.

National Mental Health Association. (1989). *Invisible Children Project: Final Report and Recommendations.* Alexandria, VA: National Mental Health Association.

Pires, S. (1991). *State Child Mental Health Planning.* Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

Saxe, L., Cross, T., Silverman, N. and Batchelor, W., with Daugherty, D. (1986). *Children's Mental Health: Problems and Services.* Durham, NC: Duke University Press. (Original work published 1987 by the Office of Technology Assessment, U.S. Congress; OTA-BP-H-33; Washington, DC: Government Printing Office.

Stroul, B. and Friedman, R. (1986). *A System of Care for Severely Emotionally Disturbed Children and Youth.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

APPENDICES

CHILD MENTAL HEALTH WORKFORCE ISSUES/STRATEGIES SURVEY

Return To: Human Service Collaborative
2262 Hall Place, NW, Suite 204
Washington, DC 20007

Questions? Call Sheila Pires - (202) 333-1892

PLEASE BE ASSURED THAT ALL IDENTIFYING INFORMATION WILL BE KEPT CONFIDENTIAL

Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

Fax Number: ______________________________

Please indicate whether you are (check all that apply):

_____ a parent of a child or adolescent with a serious emotional disorder/mental illness
_____ a State mental health commissioner
_____ a State mental health agency HRD manager
_____ a State mental health agency CASSP Director
_____ a State mental health agency SMHRCY representative
_____ a local mental health service provider (private)
_____ a local mental health service provider (State operated)
_____ a State-level mental health service provider
_____ a representative of a State or local advocacy organization
_____ a representative of another child-serving system, such as education, child welfare, juvenile justice, etc.
_____ a State or local legislator
_____ a representative from higher education
_____ other (please identify)______________________________

DUE DATE: MARCH 6, 1992

GENERAL INSTRUCTIONS

The survey is divided into 11 sections. Most questions can be answered with checkmarks. There are one or two open-ended questions in each section, and we ask that you answer these questions as concisely as possible.

The survey is being sent to a diverse group of key informants (who were identified by State Mental Health Commissioners and State HRD Managers) in each of the 12 states in the region. Because the group is diverse, we do not expect every respondent to be able to answer every question. Please feel free to leave questions blank that you do not feel comfortable answering. At the same time, we welcome your opinion, even if you feel you do not know "the answer" per se.

The questions address themselves to HRD issues in the public mental health system in your State. By "public mental health system", we mean both publicly operated programs and services, as well as private programs with which the public system may contract. Please include in your answers HRD issues affecting both publicly operated programs and private agencies that are providing services on behalf of the public system.

Surveys are, by their nature, somewhat restrictive. We welcome any explanatory notes you wish to provide to your answers!

Please return the survey to:

Pires/Kagen
Human Service Collaborative
2262 Hall Place, NW
Suite 204
Washington, DC 20007

A self-addressed, stamped envelope is enclosed for your convenience.

THANK YOU FOR YOUR HELP.

Section I. This section relates to the goals and objectives of the public child mental health system in your State over the next five years. All States have been required by Public Law 99-660, the State Comprehensive Mental Health Services Plan Act, to develop plans to create community-based service systems for children and adolescents with serious emotional disorders/mental illness and their families. This section will help us to identify the most important directions in which your State wishes to head over the next five years.

1) What are the 3 to 5 most critical goals or objectives of your State over the next five years with respect to the development of a community-based service system for children and adolescents with serious emotional disorders/mental illness and their families?

2) Is your State developing or planning to develop: (please check all that apply)

_____ more community-based services

_____ new types of community-based services, such as: (please check all that apply)

    _____ therapeutic foster care, professional parenting, family treatment homes
    _____ in home services (crisis or longer term)
    _____ respite services
    _____ day treatment or psychoeducational programs
    _____ therapeutic nursery or day care
    _____ intensive case management
    _____ community-based (as opposed to out-of-state) residential treatment facilities
    _____ therapeutic group homes
    _____ crisis intervention
    _____ supervised independent living for older adolescents
    _____ other (please identify) ________________________________

_____ family support and advocacy programs

_____ culturally competent services

_____ State-level interagency coordinating bodies

_____ local-level interagency coordinating bodies

_____ central intake or other gatekeeping mechanisms at the State or local levels

_____ joint initiatives between:

    _____ mental health and child welfare
    _____ mental health and juvenile justice
    _____ mental health and education
    _____ mental health and substance abuse
    _____ mental health and health
    _____ mental health and runaway and homeless youth programs

_____ new financing mechanisms (e.g. expansion of Medicaid usage; use of Title IV-E; blended funding; redistribution of inpatient or residential treatment dollars to community-based services, etc.)

_____ other (please identify) ____

3) Of those you have checked above, which would you designate as the three top priorities of your State over the next five years?

Section II. This section relates to the major HRD issues associated with the development of community-based services for children and adolescents with serious emotional disorders/mental illness and their families. It is intended to help us get an overview of the key HRD concerns in your State with respect to community-based service delivery for this population.

1) With respect to the development of community-based services for children and adolescents with serious emotional disorders/mental illness and their families, which of the following are major HRD concerns in your State? (Please check all that apply.)

_____ lack of sufficient knowledge in the State about the staffing patterns (i.e., the numbers, types, skills and mix of staff) required for new community-based service components
_____ ability to recruit sufficient numbers of personnel to adequately staff community-based service components
_____ ability to recruit appropriately trained staff
_____ appropriateness and adequacy of academic training
_____ retention of staff
_____ achievement of desired racial, ethnic and cultural diversity among staff
_____ achievement of the desired distribution of staff among the different service components (i.e., to minimize staff shortages in certain types of services)
_____ achievement of the desired distribution of staff geographically (i.e., to minimize staff shortages in certain areas of the State, such as rural communities)
_____ adequate in-service training
_____ having sufficient capacity in the State to assess, address and track HRD issues with respect to child mental health services
_____ other (please identify) ____

Please go back and prioritize by numbering the items you would designate as the top three HRD concerns.

2) To help us gauge how important HRD issues are to the development of community-based services in your State, please check the statement below that most closely applies.

For the development of quality community-based services for children and adolescents with serious emotional disorders/mental illness and their families, successfully addressing HRD issues is

_____ more critical than
_____ as critical as
_____ less critical than

securing adequate funding.

Section III. This section relates to knowledge about staffing patterns -- i.e., the numbers, types, skills and mix of staff needed to implement priority areas in the State. It is intended to help us identify the extent to which States have identified the staffing patterns required for implementation of priority areas. For example, if a State priority is to develop intensive case management services, has the State been able to identify how many staff are needed and what types, what skills are required and the mix of staff that is desirable?

1) Is there sufficient knowledge in the State about:

a) the number of staff needed to implement priority areas?
_____ yes _____ no

b) the skills that are required?
_____ yes _____ no

c) the types of staff needed (i.e., by discipline, professional vs. paraprofessional, racial and ethnic composition, etc.)?
_____ yes _____ no

d) mix of staff needed?
_____ yes _____ no

e) distribution of staff (i.e., where/how should staff be deployed)?
_____ yes _____ no

2) If you have checked "no" to any of the above, what is the key missing piece of information with respect to staff requirements for implementing priority areas? (Please prioritize by checking only one)

_____ how many staff are needed
_____ what are the skills required
_____ what are the types of staff needed
_____ what is the desirable mix of staff
_____ how should staff be deployed

3) Does your State have information available related to staffing patterns/requirements that would be useful to other States in the region that are developing community-based systems of care for children and adolescents with serious emotional disorders/mental illness and their families?

_____yes (if checked, please identify) _____ no

Section IV. This section relates to the issue of whether States have access to sufficient numbers of appropriately trained staff to implement priority areas. Section IV - Part One addresses the question of whether States have access to sufficient numbers of staff, regardless of how appropriately trained they are. Section IV - Part Two addresses the issue of whether States have access to appropriately trained staff.

Section IV - Part One (Sufficient Numbers of Staff)

1) Regardless of how appropriately trained staff are, does the State have access to sufficient numbers of staff to implement priority areas for delivering community-based services to children and adolescents with serious emotional disorders/mental illness and their families?

Overall	_____ yes	_____ no
By Discipline:		
Psychiatrists	_____ yes	_____ no
Child Psychiatrists	_____ yes	_____ no
Psychologists	_____ yes	_____ no
Social Workers (M.S.W.)	_____ yes	_____ no
Social Workers (Bachelors)	_____ yes	_____ no
Special Educators	_____ yes	_____ no
Psychiatric Nurses (RN)	_____ yes	_____ no
Psychiatric Nurses (LPN)	_____ yes	_____ no
Adjunctive Therapists (i.e., music therapists, recreation therapists, speech therapists, etc.)	_____ yes	_____ no
Mental Health Counselors or Technicians (Bachelors or less)	_____ yes	_____ no
Paraprofessionals	_____ yes	_____ no
Administrative and support staff	_____ yes	_____ no
Parents in Staff Roles	_____ yes	_____ no
Staff of color	_____ yes	_____ no
Other (please identify) ______________________________	_____ yes	_____ no

If you have checked "no" anywhere on the above, please go back and prioritize by numbering the top three most critical shortage areas.

2) Are these shortages due to:

_____ insufficient funding to hire staff
_____ insufficient numbers of persons being trained
_____ insufficient numbers entering the public system
_____ salaries too low
_____ unattractive benefits
_____ geographic area is undesirable
_____ service location is undesirable (i.e., program is located in a setting, such as a juvenile detention facility, that staff feel is unattractive or unsafe)
_____ lack of advancement opportunities
_____ hiring freezes
_____ poor recruitment system
_____ inefficiency of state personnel system (for example, paperwork takes too long to process so potential hirees go elsewhere)
_____ inability to retain staff
_____ other (please identify)____

Please go back and prioritize by numbering the top three reasons for shortages.

3) What specific activities, if any, are going on in the State to address these shortages? Please be as specific and concise as possible so that your response might be helpful to other States in the region facing similar shortages and who are interested in strategies to alleviate them. (You may use back of sheet.)

Section IV - Part Two (Appropriateness of Pre-Service Training)

1) Regardless of whether the State has access to adequate numbers of staff, are the staff to which it does have access appropriately trained to implement State priority areas in delivering community-based services for children and adolescents with serious emotional disorders/mental illness and their families?

_____ yes _____ no

2) In which of the State's priority areas is lack of adequate preparation and training especially a problem?

3) What are the major skills or areas of knowledge related to State priorities that are missing in staff?

4) In which of the disciplines or categories of staff is lack of adequate preparation and training especially a problem?

- _____ Psychiatrists
- _____ Child Psychiatrists
- _____ Psychologists
- _____ Social Workers (M.S.W.)
- _____ Social Workers (Bachelors)
- _____ Special Educators
- _____ Psychiatric Nurses (RN)
- _____ Psychiatric Nurses (LPN)
- _____ Other (please identify) ____
- _____ Adjunctive Therapists (i.e., music therapists, recreation therapists, speech therapists, etc.)
- _____ Mental Health Counselors or Technicians (Bachelors or less)
- _____ Paraprofessionals
- _____ Administrative and support staff
- _____ Parents in Staff Roles
- _____ Staff of Color

5) In which of the disciplines or categories of staff is lack of adequate preparation and training not a problem (i.e., staff are adequately prepared)?

6) What do you feel are the major reasons that staff are not adequately prepared?

_____ university curricula is not relevant to State priority areas

If you have checked this, please describe the three major weaknesses of current curricula to prepare staff adequately.

- _____ insufficient opportunities for students to do practicums and internships in the public child mental health system
- _____ limited faculty exposure to and understanding of State priority areas
- _____ university or accrediting body administrative barriers to development of relevant curricula or field experiences
- _____ child mental health system relies on staff from the adult mental health system who are not trained in children's area
- _____ system relies on paraprofessionals who do not receive adequate pre-service training
- _____ other (please describe)____

7) What activities are underway in the State to address the problem of staff not being adequately prepared? Please be as specific and concise as possible so that this information might be helpful to other States in the region looking for effective strategies.

Section V. This section relates to in-service training.

1) On a scale of 1-low to 10-high, to what extent is there a need to provide in-service training to ensure appropriate staff skills to implement State priority areas for delivering community-based services for children and adolescents with serious emotional disorders/mental illness and their families?

2) On the scale of 1-low to 10-high, to what extent is in-service training needed to teach staff new skills needed for new service technologies?

3) What are the three most important new skills for new service technologies staff need to learn?

4) On the scale of 1-low to 10-high, to what extent is in-service training needed because staff have inappropriate skills or attitudes for working with children and adolescents with serious emotional disorders/mental illness and their families?

5) What are the three major areas where inappropriate skills and attitudes are an issue?

6) Are appropriate in-service training curricula, training methods and training personnel available?
_____ yes   _____ no (please specify which are not available)

7) If you checked "no" to #6, is unavailability due to:

_____ lack of curricula
_____ lack of funding to do training
_____ lack of trainers
_____ other (please identify) ____

8) On a scale of 1 (none) to 10 (extensive), to what extent is the State conducting in-service training related to priority areas for delivering community-based services for children?

9) Please describe any innovative in-service training activities in the State related to delivering community-based services for children and adolescents with serious emotional disorders/mental illness and their families (i.e., development of curricula in new program areas; university-state linkages; parent/professional training; etc.)

Section VI. This section relates to recruitment issues.

1) From where does your State draw staff for the child and adolescent system? (Please estimate a percentage for each of those you check below - even a rough estimate is fine - does not have to equal 100%!)

_____ the adult mental health system - est. % _______
_____ other public child-serving agencies (i.e., education, child welfare, juvenile justice, health, etc.) - est. % _______
If you checked this category, is there one system in particular from which the child mental health system draws staff?

_____ private for profit sector (including private practice) - est. % _______
_____ private non profit sector - est. % _______
_____ other States' mental health systems - est. % _______
_____ higher education (includes university, 4-year college, 2-year college) graduating students - est. % _______
_____ higher education faculty - est. % _______
_____ vocational/technical schools - est. % _______
_____ secondary schools - est. % _______
_____ parents - est. % _______
_____ other (please identify) - est. % _______________________________

2) Of those staff drawn from higher education, please estimate from where they are recruited:

_____ Associates level - est. % _______
_____ Bachelors level - est. % _______
_____ Masters level - est. % _______
_____ Doctoral level - est. % _______

_____ 4-year public colleges/universities - in State - est. % _______
_____ 4-year public colleges/universities - out of State but in region - est. % _______
_____ 4-year public colleges/universities - out of State/region - est. % _______

_____ historic black colleges/universities - in State - est. % _______
_____ historic black colleges/universities - out of State but in region - est. % _______
_____ historic black colleges/universities - out of State/region - est. % _______

_____ private universities/colleges - in the State - est. % _______
_____ private universities/colleges - out of the State, but in region - est. % _______
_____ private universities/colleges - out of the State, not in region - est. % _______

_____ community colleges - est. % _______

3) Which of the following does your State have the most difficulty recruiting? Please identify the top three.

_____ senior managers
_____ administrative support staff
_____ clinical staff
_____ other direct care staff
_____ mid level managers
_____ program supervisors
_____ case managers
_____ other (please identify)

4) Which of the above does your State have the least difficulty recruiting?

5) Which of the following disciplines or categories of staff does your State have the most difficulty recruiting? Please identify the top three.

_____ Psychiatrists
_____ Psychologist
_____ Social Workers (Bachelors)
_____ Psychiatric Nurses (RN)
_____ Adjunctive Therapists
_____ Paraprofessionals
_____ Staff of color
_____ Child Psychiatrists
_____ Social Workers (MSW)
_____ Special Educators
_____ Psychiatric Nurses (LPN)
_____ Mental Health Counselors/Technicians
_____ Parents in staff roles
_____ Other (please identify)

6) Which of the above disciplines or categories of staff does your State have the least difficulty recruiting? Please identify the top three.

7) Please identify the top three types of community-based services where your State has the most difficulty recruiting staff (i.e., outpatient, day treatment, in-home, case management, residential, etc.).

8) Please identify the top three types of community-based services where your State has the least difficulty recruiting staff (i.e., outpatient, day treatment, in-home, case management, residential, etc.).

9) Who does recruitment for your State's child mental health system?

_____ the children's system
_____ central personnel office in the State mental health agency
_____ central personnel office in umbrella human services agency
_____ central State personnel agency
_____ contract personnel specialists
_____ other (please identify) ______________________________

10) Please describe briefly the strengths and weaknesses of the recruitment process for your State's child mental health system.

Strengths:

Weaknesses:

11) Please describe effective recruitment strategies in your State for the children's system. Please be as specific and concise as possible to be helpful to other States in the region.

Section VII. This section relates to retention issues.

1) On a scale of 1-low to 10-high, to what extent is retention of staff in the children's system a problem in your State?

2) Why do staff leave? Please prioritize by numbering the top five reasons.

____ better salaries
____ better hours and working conditions
____ opportunities for advancement
____ access to child care
____ more manageable caseloads (more realistic workload)
____ frustration with bureaucracy
____ better benefits
____ lack of status
____ fear of liability
____ too much paperwork
____ concern about personal safety (i.e., job dangerous)
____ feel unappreciated by administration
____ feel ineffective with client population because of lack of adequate knowledge/skills
____ feel ineffective with client population because of lack of access to resources/services
____ feel in conflict with policies/direction of administration
____ other (please identify) ________________________________

3) Where do staff go when they leave? Please prioritize by numbering the top five.

____ private non profit sector
____ private practice
____ private for profit sector (not private practice; i.e., a for profit hospital)
____ other public child-serving systems (i.e., education, child welfare, juvenile justice, health, etc.) -- please indicate if there is a preponderance of staff going to one of these systems in particular
____ return to school
____ higher education as staff or faculty
____ out of the field altogether
____ other (please identify) ________________________________

4) Which of the following does your State have the most difficulty retaining? Please identify the top three.

____ senior managers
____ administrative support staff
____ case managers
____ other direct care staff
____ mid level managers
____ program supervisors
____ clinical staff
____ other (please identify)

5) Which of the above does your State have the least difficulty retaining?

6) Which of the following disciplines or categories of staff does your State have the most difficulty retaining? Please prioritize by numbering the top three.

____ Psychiatrists
____ Psychologist
____ Social Workers (Bachelors)
____ Psychiatric Nurses (RN)
____ Adjunctive Therapists
____ Paraprofessionals
____ Staff of color
____ Child Psychiatrists
____ Social Workers (MSW
____ Special Educators
____ Psychiatric Nurses (LPN)
____ Mental Health Counselors/Technicians
____ Parents in staff roles
____ Other (please identify)

7) Which of the above disciplines or categories of staff does your State have the least difficulty retaining?

8) Please identify the top three types of community-based services where your State has the most difficulty retaining staff (i.e., outpatient, day treatment, in-home, case management, residential, etc.).

9) Please identify the top three types of community-based services where your State has the least difficulty retaining staff (i.e., outpatient, day treatment, in-home, case management, residential, etc.).

10) Please describe effective activities/strategies in your State to improve retention of staff. Please be as specific as possible to be helpful to other States in the region. (You may use back of sheet.)

Section VIII. This section relates to staff distribution and utilization issues.

1a) For which service types does your State have the most difficulty recruiting and retaining staff? Please identify the top three.

_____ clinic outpatient services
_____ therapeutic nursery or day care
_____ case management services
_____ therapeutic group homes
_____ inpatient hospital
_____ in home services
_____ administration and support services
_____ day treatment or psychoeducational programs
_____ respite services
_____ therapeutic foster care
_____ residential treatment facilities
_____ crisis services
_____ supervised independent living
_____ other (please identify)

1b) Please describe briefly why it is difficult to recruit and retain staff for these services.

2a) For which of the services above does your State have the least difficulty recruiting and retaining staff? Please indicate top three.

2b) Please describe briefly why it is not difficult to recruit and retain staff for these services.

3) For which service locations does your State have the most difficulty recruiting and retaining staff? Please identify the top three.

_____ school based
_____ mental health clinic based
_____ hospital based
_____ residential setting
_____ services in a juvenile corrections setting
_____ services in a child welfare system setting (for example, in child protective services)
_____ services in a primary health care setting
_____ other (please identify)____

4) For which of the above settings does your State have the least difficulty recruiting and retaining staff? Please identify top three.

5) What are the most understaffed geographic areas of your State? (i.e. rural communities, inner city neighborhoods, etc.)

6) Please describe effective activities/strategies in your State to get staff to go to and stay in underserved areas, service settings or services. Please be as specific and concise as possible to be helpful to other States in the region.

Section IX. This section relates to the relationship in your State mental health agency between the child mental health system and the State agency's human resource development (HRD) capacity.

1) Does your State mental health agency have an HRD office or other specific HRD capacity?

_____ yes _____ no

2) If yes, does it include a specific focus on child mental health workforce issues?

_____ yes _____ no

3) Does your State have or has it had a National Institute of Mental Health (NIMH) HRD grant?

_____ yes _____ no

4) If yes, does or did the grant include a specific focus on child mental health workforce issues?

_____ yes _____ no

5) If yes, please describe briefly.

6) Does your State's child mental health system work collaboratively with your State's HRD office? If so, how?

7) Who in your State has the major responsibility for child mental health HRD activities?

Section X. This section relates to the issue of linkages between your State's child mental health system and institutions of higher education to address workforce issues, particularly the issue of ensuring adequate numbers of appropriately trained staff for the public system.

1) Does your State have specific linkages with institutions of higher education to improve the quantity and quality of staff for the public child mental health system? If yes, please describe briefly.

2) If you answered "no" to the above, does your State want to establish linkages with institutions of higher education to address workforce issues for the children's system?

_____ yes _____ no

3) What are the major barriers to State agency/higher education linkages in your State?

Section XI. This section allows you to add any other information you feel will help us to understand HRD issues in your State related to the delivery of community-based services for children and adolescents with serious emotional disorders/mental illness and their families. Also, please add any information not captured above relating to effective activities/strategies in your State to address workforce issues in the children's area.

WE WELCOME ANY MATERIALS THAT YOU FEEL WOULD BE HELPFUL TO OTHER STATES IN THE REGION RELATING TO THE HRD AREA.

THANK YOU FOR YOUR TIME AND THOUGHTFULNESS IN COMPLETING THIS SURVEY!

APPENDIX B

SOUTHERN HUMAN RESOURCE DEVELOPMENT
CONSORTIUM FOR MENTAL HEALTH

2414 Bull Street/P.O. Box 485
Columbia, South Carolina 29202
Telephone: 803-734-7898
Fax: 803-734-7897

Recently, you received a letter from Sally Hein, Executive Director of the Southern Human Resource Development Consortium for Mental Health, regarding the Consortium's project to examine workforce issues related to the delivery of community-based services for children and adolescents with serious emotional disorders/mental illness and their families.

In her letter, Dr. Hein alerted you to a survey you would be receiving from us to identify key issues and effective strategies related to the preparation, recruitment, retention and distribution of staff to deliver community-based services for children and their families. ATTACHED IS THIS SURVEY. WE WOULD GREATLY APPRECIATE YOUR COMPLETING THE SURVEY AND RETURNING IT TO US NO LATER THAN MARCH 6, 1992.

The 12 southern states that comprise the Southern HRD Consortium have placed a priority on addressing workforce issues related to child mental health service delivery. Across the country, states are moving to develop community-based systems of care for children and adolescents with serious emotional disorders/mental illness and their families, which creates significant workforce issues and challenges. Are there sufficient numbers of staff? Are staff appropriately trained? Are staff oriented to working with parents? How do we recruit staff to underserved areas of the State? These are just some of the concerns that HRD addresses.

Your input is crucial in determining the range of issues involved, and strategies available, to ensure adequate numbers of appropriately trained, wisely utilized staff to deliver quality community-based services. This survey is an important first step to addressing regional workforce issues in the child mental health area. We greatly appreciate your help and will share the results with you for use in your own State.

Sincerely,

Sheila A. Pires	Ellen B. Kagen
Human Service Collaborative	CASSP Technical Assistance Center

cc: Stuart Broad, HRD Division Administrator, NASMHPD
Roy Praschil, SMHRCY Division Administrator, NASMHPD
Lemuel Clark, M.D., Chief, Clinical Training Branch, NIMH
Judith Katz-Leavy, Chief, Technical Assistance, CASSP, NIMH
Maury Lieberman, Chief, State Mental Health Planning, NIMH
Susan Salasin, Chief, Human Resource Development Program, NIMH

Alabama • Arkansas • Florida • Georgia • Kentucky • Louisiana • Mississippi • North Carolina • Oklahoma • South Carolina • Tennessee • Texas

Sally L. Hein, Ph.D., Executive Director

Southern HRD Consortium for Mental Health/Center for Mental Health Services